

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10896
72

1092? CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)	
<i>Anne Arundel</i> MARYLAND		b. STATE <i>Md</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)	
<i>Harmans</i>		<i>Harmans</i>	
c. LENGTH OF STAY IN 1b <i>1 mo.</i>		d. STREET ADDRESS <i>Sleipley Ave</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Shipley Ave</i>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <i>Melitta Grace Applequist</i>		First <i>Melitta</i>	Middle <i>Grace</i>
		Last <i>Applequist</i>	4. DATE OF DEATH <i>No. 6</i>
5. SEX <i>F</i>	6. COLOR OR RACE <i>W.</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>10-13-19</i>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>clerk</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Stiffey</i>	
10c. BIRTH PLACE (State or foreign country) <i>Balto, Co</i>		11. BIRTH PLACE (State or foreign country) <i>Balto, Co</i>	
12. CITIZEN OF WHAT COUNTRY? <i>White ave</i>		13. FATHER'S NAME <i>Henry J. Baumgartner</i>	
14. MOTHER'S MAIDEN NAME <i>Annie C. Hartline</i>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <input checked="" type="checkbox"/>	
16. SOCIAL SECURITY NO. <i>218-09-229</i>		17. INFORMANT <i>Kermit Baumgartner</i>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>PULMONARY EDEMA</i> <i>170X</i>		INTERVAL BETWEEN ONSET AND DEATH <i>11 HRS.</i>	
DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause lost. <i>(b) CONGESTIVE HEART FAILURE</i>		3 DAYS.	
DUE TO <i>(c) METASTATIC CARCINOMA LEFT BREAST</i>		9 MOS.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <i>19</i>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <i>11-5</i> , 19 <i>56</i> , to <i>11-7</i> , 19 <i>56</i> , that I last saw the deceased alive on <i>11-7</i> , 19 <i>56</i> , and that death occurred at <i>12:21 AM</i> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED ACTUAL SIGNATURE <i>Leon C. Perry</i> PHYSICIAN'S NAME (Type) <i>LEON C. PERRY, MD</i>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		22b. DATE THEREOF <i>11/9/56</i>	
22c. NAME OF CEMETERY OR CREMATORIUM <i>Emmanuel Cem</i>		22d. LOCATION (City, town, or county) (State) <i>Balto Md</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>Paul A Neumann</i>		ADDRESS <i>6067 Hay Rd</i>	
24a. REC'D BY REGISTRAR DATE <i>11-9 1956</i>		24b. REGISTRAR'S SIGNATURE <i>Clara Harlop</i>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be signed by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 & 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

OPTIONAL FORM OF ANSWER-QUESTION

OPTIONAL FORM OF ANSWER-QUESTION

BUREAU V.

NOV 9 1956

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10899 CERTIFICATE OF DEATH

10897
Reg. Dist. No. 21

1. PLACE OF DEATH a. COUNTY Anne Arundel		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland		b. COUNTY Anne Arundel	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Annapolis		c. LENGTH OF STAY IN 1b RURAL AND GIVE NEAREST TOWN		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Annapolis		d. STREET ADDRESS 106 N. Linden Ave.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Anne Arundel General Hospital				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)	First FRANK	Middle G	Last BALDWIN	4. DATE OF DEATH Month November	Month 12	Day 19	Year 56
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	B. DATE OF BIRTH Feb. 7, 1898	9. AGE (In years last birthday) 58 yrs.	IF UNDER 1 YEAR Months 58	IF UNDER 24 HRS. Days 0	Hours 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Proprietor		10b. KIND OF BUSINESS OR INDUSTRY Farm Equipment Co.		11. BIRTHPLACE (State or foreign country) Millersville, Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME William E. Baldwin Sr.		14. MOTHER'S MAIDEN NAME Annastusia A. Deutsch					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 220-16-4735		17. INFORMANT Address Mrs Belle Baldwin- Wife- Same as # 2			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]							
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Coronary Thrombosis & Block Atherosclerotic Heart Disease INTERVAL BETWEEN ONSET AND DEATH days various							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)							
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from July, 1954 , to 12 nov. 1956 , that I last saw the deceased alive on 12 nov. 1956 , and that death occurred at 7:22 PM , from the causes and on the date stated above.							
ACTUAL SIGNATURE Edward S. Beck ADDRESS (Street, city or town, state) M.D. 41 Southgate Ave, Annapolis, Maryland DATE SIGNED 11/15/56							
PHYSICIAN'S NAME (Type) Edward S. Beck		M D		41 Southgate Ave, Annapolis, Maryland			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Nov. 15, 1956		22c. NAME OF CEMETERY OR CREMATORIUM St. Mary's Cemetery		22d. LOCATION (City, town, or county) (State) Annapolis, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE HOPPING FUNERAL HOME		ADDRESS ANNAPOULIS, MARYLAND		24e. REC'D BY REGISTRAR JW		24f. REC'D BY DIRECTOR'S SIGNATURE VS A15 (4) 15M 9/55	

ALL INFORMATION CONTAINED
HEREIN IS UNCLASSIFIED

DATE 11/16/18 BY SP/1000

BUREAU V. S.

NOV 16 1956

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10898
28

10928 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Anne Arundel		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Maryland		b. COUNTY Baltimore City			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Crownsville		c. LENGTH OF STAY IN lb 10mos. 6 days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore City		d. STREET ADDRESS 1600 N. Gilmore St.			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Crownsville State Hospital						e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)		First Ethel	Middle 	Last Barnes	4. DATE OF DEATH 11 12 19 56	Month 11	Day 12	Year 19 56	
5. SEX Female		6. COLOR OR RACE Negro	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 8/4/00	9. AGE (in years last birthday) 56 yrs.	10. IF UNDER 1 YEAR — Months —	11. IF UNDER 24 HRS. — Days —	Hours —	Min. —
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY — — —		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U. S.			
13. FATHER'S NAME Alphonsus Curtis		14. MOTHER'S MAIDEN NAME Mary Curtis							
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Unk.		16. SOCIAL SECURITY NO. Unk.		17. INFORMANT Hospital Records		Address Crownsville State Hospital Crownsville, Maryland			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Uremia						INTERVAL BETWEEN ONSET AND DEATH			
442 X Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) Renal Failure									
DUE TO Renal Failure									
DUE TO (c) Hypertensive Cardiovascular Disease									
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Hypostatic Pneumonia, Decubitus Ulcers									
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) Crownsville, Md.		(County) 	(State)
21. I certify that I attended the deceased from 7/9 , 19 56 , to 11/12 , 19 56 , that I last saw the deceased alive on 7/9 , 19 56 , and that death occurred at 12:10 p.m. From the causes and on the date stated above. ACTUAL SIGNATURE <i>Lionel McHenry Mapp.</i>						ADDRESS (Street, city or town, state) Crownsville, Md.			
PHYSICIAN'S NAME (Type) Lionel McHenry Mapp.						DATE SIGNED 11/13/56			
22a. BURIAL, CREMATION, REMOVAL (Specify) 11/20/56		22b. DATE THEREOF 11/20/56		22c. NAME OF CEMETERY OR CREMATORIY St. Peter Cemetery Baltimore		22d. LOCATION (City, town, or county) Baltimore		(State) Md.	
23. FUNERAL DIRECTOR'S SIGNATURE <i>George G. Nelson</i>		ADDRESS 1348 W. Calhoun St.		24a. REC'D BY REGISTRAR NOV 19 1956		24b. REGISTRAR'S SIGNATURE <i>J. M. Joyce</i>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician
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BUREAU V. S.
RECEIVED
NOV 19 1956

ALL INFORMATION CONTAINED
HEREIN IS UNCLASSIFIED BY [redacted]

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
 Items 9,13,14 Film G206 11-14-56 st
CERTIFICATE OF DEATH

10899

Reg. Dist. No. 22

1. PLACE OF DEATH o. COUNTY Anne Arundel		10929 MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) o. STATE Maryland		b. COUNTY Anne Arundel	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Fort George G. Meade		c. LENGTH OF STAY IN 1b 14 Months		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Fort George G. Meade		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION U. S. Army Hospital		d. STREET ADDRESS 1609 E Forrest Avenue		d. DATE OF DEATH November 1 1956			
3. NAME OF DECEASED (Type or print) RICHARD		First HARRISON Middle BARNES Last		Month November Day 1 Year 1956			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH 31 January 1917	9. AGE (In years lost birthday) 38 39yrs.	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Soldier		10b. KIND OF BUSINESS OR INDUSTRY U. S. Army		11. BIRTHPLACE (State or Foreign country) Georgia		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME (Deceased) Charles H. Barnes		14. MOTHER'S MAIDEN NAME (Deceased) Dora Hedden					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes		16. SOCIAL SECURITY NO. None		17. INFORMANT Wife, Mrs. Darie J. Barnes, 1609 E Forrest Avenue, Meade Heights, Maryland		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute occlusion, right coronary artery		DUE TO				INTERVAL BETWEEN ONSET AND DEATH DOA	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b)		DUE TO					
(c)							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)						19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) M.D. USAHM Ft. G. Meade, Maryland		20f. (City or town) (County) Arlington (State) Virginia	
21. I certify that I attended the deceased from _____, 19_____, to _____, 19_____, that I last saw the deceased alive on _____, 19_____, and that death occurred at _____, M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED							
ACTUAL SIGNATURE <i>Israell S. Elliott</i>		22. BURIAL, CREMATION, DATE THEREOF REMOVAL (Specify) Burial 11-5-56					
PHYSICIAN'S NAME (Type) ISRAEL S. ELLIOTT, LT COL, MC		22c. NAME OF CEMETERY OR CREMATORIAL Arlington National		22d. LOCATION (City, town, or county) Arlington, Virginia (State)			
23. FUNERAL DIRECTOR'S SIGNATURE <i>John Cooke Inc.</i>		ADDRESS 1217 St. Paul St. WM COOKE, INC., Baltimore, Maryland		24a. REC'D BY REGISTRAR DATE 1 Nov 56		24b. REGISTRAR'S SIGNATURE W.L.Saylor, 1ST LT, MSC	

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TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BY JONATHAN LEE HARRIS AND ROBERT W. BROWN

BUREAU Y. S.

NOV 8 1956

REGELIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10900 CERTIFICATE OF DEATH

10900

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <i>A.A.</i>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>Md.</i> b. COUNTY <i>A.A.</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Annapolis</i>		c. LENGTH OF STAY IN lb		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Annapolis</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>U.S. A.G. General</i>		d. STREET ADDRESS <i>1009 Poplar Ave.</i>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)	First <i>FRANK</i>	Middle <i>W.</i>	Last <i>BEACHLEY</i>	4. DATE OF DEATH Month <i>11</i> - Day <i>24</i> Year <i>1956</i>	
5. SEX <i>MALE</i>	6. COLOR OR RACE <i>WHITE</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH <i>7-24-1912</i>	9. AGE (In years last birthday) <i>44 yrs.</i>	IF UNDER 1 YEAR Months <i>0</i> Days <i>0</i> Hours <i>0</i> Min. <i>0</i> IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Salesman</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Wholesale Meat</i>		11. BIRTHPLACE (State or foreign country) <i>Williamsport Md</i>	
12. CITIZEN OF WHAT COUNTRY? <i>N. S.A.</i>					
13. FATHER'S NAME <i>Orville L. Beachley</i>		14. MOTHER'S MAIDEN NAME <i>Bessie Taylor</i>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>		16. SOCIAL SECURITY NO. <i>214-03-1178</i>		17. INFORMANT <i>Grace Smith Beachley</i>	
				Address <i>②</i>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]					
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Auto myocardial infarction</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>Coronary artery disease</i> DUE TO (c)					
INTERVAL BETWEEN ONSET AND DEATH <i>20 min.</i>					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour p. m. <i>19</i>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <i>20</i> (City or town) <i>(County)</i> <i>(State)</i>	
21. I certify that I attended the deceased from <i>August</i> , 19 <i>56</i> , to <i>November</i> , 19 <i>56</i> , that I last saw the deceased alive on <i>November 19</i> , 19 <i>56</i> , and that death occurred at <i>9:20 A.M.</i> from the causes and on the date stated above. ACTUAL SIGNATURE <i>John H. Holman</i> M.D. ADDRESS (Street, city or town, state) <i>90 Cathedral St.</i> DATE SIGNED <i>11/24/56</i>					
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		22b. DATE THEREOF <i>Nov 27-56</i>		22c. NAME OF CEMETERY OR CREMATORIUM <i>Hillcrest</i>	
22d. LOCATION (City, town, or county) <i>Annapolis</i>					
23. FUNERAL DIRECTOR'S SIGNATURE <i>John M. Taylor Sons</i>		ADDRESS <i>Annapolis Md.</i>		24a. REC'D BY REGISTRAR DATE	
				24b. REGISTRAR'S SIGNATURE	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, page 2 should be detached for use as the burial-transit permit. Then please retain carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

DEPARTMENT OF HOMELAND SECURITY - FEDERAL BUREAU OF INVESTIGATION

FD-350 (Rev. 1-25-94) CERTIFICATE OF SERVICE

FEDERAL BUREAU OF INVESTIGATION

NOV 28 1996

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10903

10930 CERTIFICATE OF DEATH

Reg. Dist. No.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, it should be filed with page 2. It should be detached for use as the burial-trust permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <i>Anne Arundel</i>		2. USUAL RESIDENCE (Where deceased lived if institution, Residence before admission) a. STATE <i>Md</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Rural</i>		c. LENGTH OF STAY IN 1b <i>11</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Indoor Blood Park Pasadena Md</i>		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Rural Fable Stone Glendale</i>	
f. STREET ADDRESS <i>Blood Park Boarding</i>		g. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <i>Walter Thomas Beall</i>	First <i>Walter</i>	Middle <i>Thomas</i>	Last <i>Beall</i>
4. DATE OF DEATH <i>Nov 27 - 1956</i>	Month <i>Nov</i>	Day <i>27</i>	Year <i>1956</i>
5. SEX <i>Male</i>	6. COLOR OR RACE <i>White</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>April 25-1894</i>
9. AGE (in years, lost birthday) <i>62 yrs.</i>	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Carpenter</i>	11. KIND OF BUSINESS OR INDUSTRY <i>/</i>	12. BIRTHPLACE (State or foreign country) <i>Montgomery Co</i>
13. FATHER'S NAME <i>Jesse Beall</i>	14. MOTHER'S MARRIED NAME <i>Maryann Robinson</i>	15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>	
16. SOCIAL SECURITY NO <i>217-14-2740</i>		17. INFORMANT <i>Mrs Emma Beall</i>	Address <i></i>
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Carcinoma of the rectum</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c)			
INTERVAL BETWEEN ONSET AND DEATH <i>3 months</i>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <i>none</i>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <i></i>	
20c. TIME OF INJURY Hour o.m. p.m.	Month 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <i>November 13, 1956</i> to <i>November 27, 1956</i> , that I last saw the deceased alive on <i>November 26, 1956</i> , and that death occurred at <i>9:15 AM</i> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <i>Pasadena, Md.</i> DATE SIGNED <i>Nov 27, 1956</i>			
ACTUAL SIGNATURE <i>R.M. McLaughlin</i>	PHYSICIAN'S NAME (Type) <i>R.M. McLaughlin</i>		
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>	22b. DATE THEREOF <i>Nov 30-56</i>	22c. NAME OF CEMETERY OR CREMATORIAL <i>Western Cemetery</i>	22d. LOCATION (City, town, or county) <i>Baltimore Md</i> (State)
23. FUNERAL DIRECTOR'S SIGNATURE <i>Bernard G. Trindell, Elan Burns, Jr.</i>		24a. REC'D BY REGISTRAR DATE <i>11-28-56</i>	24b. REGISTRAR'S SIGNATURE <i>L. J. W. 1956</i>

BUREAU Y. S.

NOV 23 1965

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10931 CERTIFICATE OF DEATH

Reg. Dist. No.

19904

1. PLACE OF DEATH a. COUNTY Anne Arundel		MARYLAND		2 USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE Maryland		b. COUNTY Howard			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Crownsville		c. LENGTH OF STAY IN 1b lyr. 9 mos. 29 days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Dayton					
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Crownsville State Hospital		d. STREET ADDRESS None given		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print)	First John	Middle	Last	4. DATE OF DEATH	Month 11	Day 16	Year 19 56		
5. SEX Male	6. COLOR OR RACE Negro	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Not given	9. AGE (In years last birthday) 81? yrs	IF UNDER 1 YEAR Months - Days -	IF UNDER 24 HRS. Hours - Min -			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farm Work		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U. S.			
13. FATHER'S NAME West Bell		14. MOTHER'S MAIDEN NAME Mary Liza Bell							
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Unk.		16. SOCIAL SECURITY NO Unk., Unk.		17. INFORMANT Hospital Records		Address Crownsville State Hospital Crownsville, Maryland			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Hypostatic Pneumonia						INTERVAL BETWEEN ONSET AND DEATH			
DUE TO Old Age									
Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) Old Age									
DUE TO (c)									
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		Pyelitis, dehydration and malnutrition				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town)		(County) (State)	
21. I certify that I attended the deceased from 11/1 , 19 56 , to 11/16 , 19 56 , that I last saw the deceased alive on 11/15 , 19 56 , and that death occurred at 10:00 AM , from the causes and on the date stated above. ACTUAL SIGNATURE <i>Lionel McHenry Mapp</i>						ADDRESS (Street, city or town, state) Crownsville, Md.		DATE SIGNED 11/16/56	
PHYSICIAN'S NAME (Type) Lionel McHenry Mapp									
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF 11-19-1956		22c. NAME OF CEMETERY OR CREMATORIUM Hopkins Chapel		22d. LOCATION (City, town, or county) HIGHLAND MD.		(State)	
23. FUNERAL DIRECTOR'S SIGNATURE F.C. Heigibottom Elliott City		ADDRESS Elliott City		24a. REC'D BY REGISTRAR Katherine Joyce		24b. REGISTRAR'S SIGNATURE Katherine Joyce			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death; Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, it should be detached for use as the Burial-Transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

W A 617

956.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

210905

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Anne Arundel				MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Same b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Severn		c. LENGTH OF STAY IN lb 20 years		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Same		d. STREET ADDRESS Same		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Old Quaterfield Rd. Box 454											
3. NAME OF DECEASED (Type or print)		First Anna		Middle Blaudow		Lost	4. DATE OF DEATH	Month	Day	Year	19 56
5. SEX F.	6. COLOR OR RACE W.	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	B. DATE OF BIRTH 3/2/88		9. AGE (In years lost birthday) 68 yrs	IF UNDER 1 YEAR IF UNDER 24 HRS.		Months	Days	Hours	Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) East Prussia, Germany.		12. CITIZEN OF WHAT COUNTRY? Germany					
13. FATHER'S NAME Unknown				14. MOTHER'S MAIDEN NAME Unknown							
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No				16. SOCIAL SECURITY NO. None				17. INFORMANT Mr. William Blaudow (husband)			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Carcinomatosis, primary source left breast								INTERVAL BETWEEN ONSET AND DEATH 6 years			
DUE TO 170X Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. Mental troubles								15 years			
DUE TO (b) Mental troubles											
(c)											
Part II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20c. TIME OF INJURY Hour a. m. p. m.		Month, Day, Year 19		20d. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) Glen Burnie, Md.		(County)	(State)
21. I certify that I attended the deceased from 10/28/56 , 19, to 11/6/56 , 19, that I last saw the deceased alive on 11/5/56 , 19, and that death occurred at 12.20 M. from the causes and on the date stated above.											
ADDRESS (Street, city or town, state) Glen Burnie, Md. DATE SIGNED 11/6/56											
ACTUAL SIGNATURE Gustave H. Faubert, M.D.											
NAME (Type) Gustave H. Faubert, M.D.											
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Nov 8-56		22c. NAME OF CEMETERY OR CREMATORIUM Holy Cross Brooklyn, N.Y.		22d. LOCATION (City, town, or county) Kittatinny Valley Md		(State)			
23. FUNERAL DIRECTOR'S SIGNATURE Edward G. Fink				ADDRESS Glen Burnie Md		24a. REC'D BY REGISTRAR DATE Nov 8-56		24b. REGISTRAR'S SIGNATURE L.J. Deaiba			

HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

BURIAL FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-funeral permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

LEIAU V. S



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10906

Reg. Dist. No. 24

10933 CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY AA		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Md.		b. COUNTY M		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sunset Beach		c. LENGTH OF STAY IN 1b Yrs.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sunset Beach				
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Sunset Beach				d. STREET ADDRESS Sunset Beach		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print)	First Neva	Middle Amanda	Last Bradshaw	4. DATE OF DEATH	Month 11	Day 18	Year 19 56	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED, WIDOWED, DIVORCED WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 2/11/83	9. AGE (In years last birthday) 73 yrs	IF UNDER 1 YEAR Months 0	IF UNDER 24 HRS. Days 0	Hours 0	Min 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Md.		12. CITIZEN OF WHAT COUNTRY? USA		
13. FATHER'S NAME James Benton				14. MOTHER'S MAIDEN NAME Josephine Evans				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO.		17. INFORMANT Family		Address Same		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CORONARY THROMBOSIS INTERVAL BETWEEN ONSET AND DEATH 2 DAYS DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause first. ARTERIOSCLEROTIC CARDIO VASCULAR DISEASE 5 YEARS DUE TO (b) ARTERIOSCLEROTIC CARDIO VASCULAR DISEASE 5 YEARS (c)								
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)								
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)						
20c. TIME OF INJURY Hour a. m. p. m.	Month 19	Day	Year	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) Baltimore, Md.	(County) Md.	(State) Md.
21. I certify that I attended the deceased from MARCH 1952 to NOV. 18, 1956 , that I last saw the deceased alive on NOV. 16, 1956 , and that death occurred at 8:30 AM , from the causes and on the date stated above. ACTUAL SIGNATURE <i>J. Brady Smith</i> ADDRESS (Street, city or town, state) PHYSICIAN'S NAME (Type) <i>J. Brady Smith</i> DATE SIGNED 11/4/56								
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 11/21/56	22c. NAME OF CEMETERY OR CREMATORIY Western Cemetery	22d. LOCATION (City, town, or county) Baltimore, Md. (State) Md.					
23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS McCully Funeral Homes — 130 E. Fort Ave.					24a. REC'D BY REGISTRAR 11-23-56	24b. REGISTRAR'S SIGNATURE <i>Louis J. Healy</i>		

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retorted by the hospital or attending physician
TO FUNERAL DIRECTOR: After this certicate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 24 hours after death.

100

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10907

10934 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH o COUNTY A.A. County		MARYLAND	2. USUAL RESIDENCE (Where deceased lived if institution Residence before admission) o STATE Maryland		b. COUNTY Baltimore
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) North Linthicum		c. LENGTH OF STAY IN 1b	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Arbutus		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
d NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Ellanora Ave.		d STREET ADDRESS 4409 Leeds Ave.			
3 NAME OF DECEASED (Type or print) ANNA VIRGINIA BRADY	First	Middle	4. DATE OF DEATH NOVEMBER 4 - TH	Month	Day Year 1956
5 SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH March 14, 1890	9 AGE (in years lost birthday) 66 yrs	10. IF UNDER 1 YEAR Months Days Hours Min
10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY At Home	11. BIRTHPLACE (State or foreign country) Baltimore Maryland	12 CITIZEN OF WHAT COUNTRY? USA	
13 FATHER'S NAME Howard E.R. Hunter		14 MOTHER'S MAIDEN NAME Sophia E. Wilkerson		Address	
15 WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No.		16 SOCIAL SECURITY NO. -----	17. INFORMANT Harvey Brady Sr., 4409 Leeds Ave.	18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 153X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. Recurrent Colonic Obstruction DUE TO (b) Recurrent Colonic Obstruction 3 mos. (c) Colicoma of Rectal Ligament 1-3 mos.	
				INTERVAL BETWEEN ONSET AND DEATH 3 days	
20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20c TIME OF INJURY Hour o. m. p. m.	Month, Day, Year 19	20d. INJURY OCCURRED White Not white at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) Baltimore	(County) (State)
21. I certify that I attended the deceased from March 14, 1956 to November 4, 1956 , that I last saw the deceased alive on November 4, 1956 , and that death occurred at 8 P.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) 1800 North Charles Street DATE SIGNED Simon Brager M.D.					
ACTUAL SIGNATURE PHYSICIAN'S NAME (Type) Simon Brager, M. D.					
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF Nov. 7-1956	22c. NAME OF CEMETERY OR CREMATORIUM Loudon Park Cemetery	22d. LOCATION (City, town, or county) Baltimore Maryland (State)		
23. FUNERAL DIRECTOR'S SIGNATURE J. B. Hibbert		ADDRESS 1300 Eutaw Place	24a. REC'D BY REGISTRAR ✓	24b. REGISTRAR'S SIGNATURE S. J. Hedrich	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

RECEIVED
OCT 7 1956

SURBAU V. S.

INSTRUCTIONS

TO A LIVING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

10908

10901 CERTIFICATE OF DEATH

Reg. Dist. No. ...

1. PLACE OF DEATH

COUNTY Anne Arundel MARYLAND
 CITY (If outside corporate limits, write RURAL
 OR and give nearest town)
 TOWN Annapolis
 HOSPITAL OR
 INSTITUTION OR
 STREET ADDRESS 66 College Creek Terrace

2. USUAL RESIDENCE (HOME) OF DECEASED

STATE Maryland COUNTY Anne Arundel
 CITY (If outside corporate limits, write RURAL and give nearest town)
 OR
 TOWN Annapolis
 STREET ADDRESS 66 College Creek Terrace
 (If rural give location)

3. NAME OF
DECEASED
(Type or Print)

(First)

(Middle)

(Last)

Joseph H. Brandford

Male Col.

Color

SINGLE, MARRIED,
WIDOWED, DIVORCED,
(Specify)

DATE OF BIRTH

AGE last birthday

4. DATE
OF
DEATH

(Month)

(Day)

(Year)

10e. USUAL OCCUPATION (Give kind of work
done during most of working life, even if
retired)10b. KIND OF BUSINESS
OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

12. CITIZEN OF WHAT
COUNTRY?

13. FATHER'S NAME

John Brandford

14. MOTHER'S MAIDEN NAME

Mary Johnson

15. WAS DECEASED EVER IN U. S. ARMED FORCES?
(Yes, No. of units, If Yes, give war or dates of service)

Yes, W.W.I 1919-16-1131

16. SOCIAL SECURITY NO.

17. INFORMANT & ADDRESS

18. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

18. MEDICAL CERTIFICATION

INTERVAL BETWEEN
ONSET AND DEATHIMMEDIATE CAUSE
(A)

Acute Coronary Thrombosis

15 minutes

ANTECEDENT CAUSE(S) DUE TO

DISEASES OR CONDITIONS, IF ANY, (B)
GIVING RISE TO THE ABOVE CAUSE
STATING UNDERLYING CAUSE LAST. DUE TO
(C)II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING DEATH

Generalized Atherosclerosis

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES NO 21a. ACCIDENT WAS UNDERLYING
OR CONTRIBUTING CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER)21b. PLACE (Home, farm, factory,
OF INJURY street, office bldg., etc.)21c. WHERE DID INJURY OCCUR? (City or town)
(County) (State)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)

21e. INJURY OCCURRED
While Not while
at work at work

21f. HOW DID INJURY OCCUR?

M.

22. I hereby certify that I attended the deceased from Aug 19, 1956, to Nov 9, 1956, that I last saw the deceased alive on Nov 9, 1956, and that death occurred at 10:10 P.M. from the causes and on the date stated above.

SIGNATURE

R. Richardson

ADDRESS (Street, city, town, state) DATE SIGNED

11/10/56

23. BURIAL, CREMATION,
REMOVAL (SPECIFY)

DATE THEREOF

NAME OF CEMETERY OR CREMATORIUM

LOCATION (City, town, or county)

(State)

24. REC'D BY REGISTRAR

REGISTRAR'S SIGNATURE

25. FUNERAL DIRECTOR'S SIGNATURE

ADDRESS

DATE

Wm. J. Leach

William Reese, Jr. Annapolis, Md

ST. AUGUSTINE

808

THE
LAW
LIBRARY

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
10902 CERTIFICATE OF DEATH

10909
21

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <i>Anne Arundel</i>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <i>Md.</i>		b. COUNTY <i>A.A.</i>					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Annapolis</i>		c. LENGTH OF STAY IN 1b RURAL OR GIVE NEAREST TOWN		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Annapolis</i>							
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>27 College Cr Tr</i>		d. STREET ADDRESS <i>27 College Cr Tr</i>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) <i>Mary</i>		First <i>#4</i>	Middle <i></i>	Last <i>Butler</i>	DATE OF DEATH <i>Nov 20</i>	Month <i>Nov</i>	Day <i>20</i>	Year <i>1956</i>			
5. SEX <i>F</i>	6. COLOR OR RACE <i>C</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <i>12-25-1897</i>	9. AGE (in years last birthday) <i>58 yrs.</i>	10. IP UNDER 1 YEAR IF UNDER 24 HRS. Months <i></i>	Days <i></i>	Hours <i></i>	Min <i></i>		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Domestic</i>		10b. KIND OF BUSINESS OR INDUSTRY <i></i>		11. BIRTHPLACE (State or foreign country) <i>Brown Woods, Md.</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>					
13. FATHER'S NAME <i>John E. Hunt</i>		14. MOTHER'S MAIDEN NAME <i>Harriett Hunt</i>									
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)		16. SOCIAL SECURITY NO. <i></i>		17. INFORMANT <i>Hollis Butler - Q.T.C. Ch. Teacher Annapolis</i>		Address <i></i>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Arteriosclerotic Heart Disease</i> DUE TO <i>4200</i> Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) DUE TO (c)										INTERVAL BETWEEN ONSET AND DEATH <i>1 yr.</i>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)										19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20c. TIME OF INJURY Hour o. m. p. m. <i>19</i>		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <i></i>		20f. (City or town) <i></i>		(County) <i></i>	(State) <i></i>		
21. I certify that I attended the deceased from <i>JAN 21</i> , 19 <i>56</i> , to <i>NOV 20</i> 19 <i>56</i> , that I last saw the deceased alive on <i>NOV 3^d</i> 19 <i>56</i> , and that death occurred at <i>155 q.M.</i> from the causes and on the date stated above. ACTUAL SIGNATURE <i>Fayre W. Allen</i> M.D.										ADDRESS (Street, city or town, state) <i>62 Cathedral St</i>	DATE SIGNED <i>11-23-56</i>
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial 11-24-56</i>		22b. DATE THEREOF <i>11-24-56</i>		22c. NAME OF CEMETERY, OR CREMATORIAL <i>Broad Neck</i>		22d. LOCATION (City, town, or county) <i>Edgewater, Md.</i>		(State) <i></i>			
23. FUNERAL DIRECTOR'S SIGNATURE <i>William Rice, Jr. - Annapolis, Md.</i>										ADDRESS <i></i>	
24a. REC'D BY REGISTRAR <i>127 Nov 27 1956</i>										24b. REGISTRAR'S SIGNATURE <i>John J. ...</i>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10903 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

10901

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <i>A.A.</i>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admis'sn) b. STATE <i>Md.</i>			
b. CITY OR TOWN (If outside corporate limits, write RURAL (and give nearest town) <i>Annapolis</i>		c. LENGTH OF STAY IN b d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <i>Williams Dr.</i>		b. COUNTY <i>A.A.</i>	
e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Annapolis</i>		d. STREET ADDRESS <i>Williams Dr.</i>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <i>PATRICIA L. CAPLE</i>		First	Middle	Last	4. DATE OF DEATH <i>11-15-1956</i>
5. SEX <i>Female</i>		6. COLOR OR RACE <i>White</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>	8. DATE OF BIRTH <i>11-20-1954</i>	9. AGE (In years last birthday) 1 yrs. IF UNDER 1 YEAR Months <i>11</i> Days <i>0</i> Hours <i>0</i> Min. IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>none</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>none</i>		11. BIRTHPLACE (State or foreign country) <i>California</i>	
12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>					
13. FATHER'S NAME <i>Edward S. Caple</i>		14. MOTHER'S MAIDEN NAME <i>Jane Louise Herrick</i>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>—</i>		16. SOCIAL SECURITY NO. <i>—</i>		17. INFORMANT <i>Edward S. Caple #2</i>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Drowning</i>				INTERVAL BETWEEN ONSET AND DEATH <i>Subd. c'</i>	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <i>[b]</i>		DUE TO <i>[c]</i>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.) <i>Fallen into the water</i>			
20c. TIME OF INJURY Month, Day, Year Hour o. m. <i>11:15</i> p. m. <i>19/6</i>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <i>Water</i>	
20f. (City or town) <i>Baltimore</i>		(County) <i>Baltimore</i>		(State) <i>Md.</i>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .					
ACTUAL SIGNATURE <i>John M. Kyson</i>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED <i>11-15-1956</i>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>BURIAL</i>		22b. DATE THEREOF <i>11/20/56</i>		22c. NAME OF CEMETERY OR CREMATORIAL <i>Arlington Nat'l Cemetery</i>	
22d. LOCATION (City, town, or county) <i>Baltimore</i>		(State) <i>Md.</i>			
23. FUNERAL DIRECTOR'S SIGNATURE <i>John M. Kyson & Sons</i>		ADDRESS <i>Annapolis, Md.</i>		24a. REC'D BY REGISTRAR <i>John M. Kyson</i>	
				24b. REGISTRAR'S SIGNATURE <i>John M. Kyson</i>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the "Cert" Face, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 back to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with Farm PM3. Page 5 may be retained by your funeral director. File pages 1 and 2 with the registration, or removal.

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10 DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your information.
FOR FUNERAL DIRECTOR: Page 3 should be used as a burial/transit permit. File page 1 and 2 with the registrar prior to burial, transit, or removal.

Item 2 & Film 208
1 MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10910

MEDICAL EXAMINER'S CERTIFICATE OF DEATH												Reg. Dist. No.	
1. PLACE OF DEATH a. COUNTY <i>A.A Co</i>				2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <i>Maryland</i> b. COUNTY <i>A.A</i>									
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Lothian</i>		c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Lothian</i>		d. STREET ADDRESS							
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)												e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)		First <i>Otis</i>	Middle <i></i>	Last <i>Chapman</i>	4. DATE OF DEATH Month <i>11</i> - Day <i>28</i> - Year <i>1956</i>								
5. SEX <i>Male</i>	6. COLOR OR RACE <i>White</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>Sept-13-1912</i>	9. AGE (In years last birthday) <i>44 yrs.</i>	10. IF UNDER 1 YEAR Months <i></i>	11. IF UNDER 24 HRS. Days <i></i>	12. IF UNDER 24 HRS. Hours <i></i>	13. IF UNDER 24 HRS. Min. <i></i>					
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Get Policeman</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Policeman</i>		11. BIRTHPLACE (State or foreign country) <i>Pace Fla</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>							
13. FATHER'S NAME <i>Otis Chapman</i>		14. MOTHER'S MAIDEN NAME <i>Mae Wyche</i>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? 16. SOCIAL SECURITY NO. (Yes, no, or unknown) <input type="checkbox"/> (If yes, give war or dates of service) <input type="checkbox"/>		17. INFORMANT <i>Mrs Elise Chapman</i>		Address <i>2</i>					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY, IMMEDIATE CAUSE (a) <i>Crushing Injury to Chest</i> 822X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO <i>Fracture of Skull</i> (c) DUE TO <i></i>												INTERVAL BETWEEN ONSET AND DEATH <i>Leaden</i>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)												19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <i>Tractor turned over on subject</i>											
20c. TIME OF INJURY Hour a. m. p. m. <i>19</i>		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <i></i>		20f. (City or town) <i></i>		(County) <i></i>		(State) <i></i>			
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> <i>Schenkhardt</i>													
ACTUAL SIGNATURE <i>E. L. Schenkhardt</i>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED <i>11/29/56</i>					
EXAMINER'S NAME (Type) <i>E. L. Schenkhardt</i>		22b. DATE THEREOF <i>12-1-56</i>		22c. NAME OF CEMETERY OR CREMATORIAL ADT. INSTITUTE <i>Georgetown Memorial</i>		22d. LOCATION (City, town, state) <i>Baltimore Md</i>		U.S. (State) <i></i>					
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <i>Hysong Funeral Home</i>		24. REC'D BY REGISTRAR DATE <i></i>		24b. REGISTRAR'S SIGNATURE <i></i>							
VS. A15ME(S) <i>1000</i>													

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10911

10904 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. 21

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute this certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with Form PHA3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the records prior to burial, cremation, or removal.

1. PLACE OF DEATH a. COUNTY <i>Anne Arundel</i>		2. USUAL RESIDENCE (Where deceased lived. If institution: Res'dence before admission) a. STATE <i>Maryland</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Annapolis</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Annapolis</i>	
c. LENGTH OF STAY IN lb		d. STREET ADDRESS <i>RFD Box 37 Millersville, Md.</i>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <i>Weems Crk.</i>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <i>Elsie Belle Chatman</i>		First	Middle
4. DATE OF DEATH <i>11 15 1956</i>		Month	Day
5. SEX <i>Female</i>		6. COLOR OR RACE <i>Colored</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>
8. DATE OF BIRTH <i>1 - 31 - 1935</i>		9. AGE (in years last birthday) <i>21 yrs.</i>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Domestic</i>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <i>Waterbury, Md</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	
13. FATHER'S NAME <i>David Ross</i>		14. MOTHER'S MAIDEN NAME <i>Genevieve Brown</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>		16. SOCIAL SECURITY NO. <i>218-32-5877</i>	
17. INFORMANT <i>Genevieve Gross - Shady Side, Md</i>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Brown</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>Sudden</i> DUE TO (c)			
INTERVAL BETWEEN ONSET AND DEATH			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.) <i>attempted to rescue child in water</i>	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <i>11/11/56</i>		20d. INJURY OCCURRED While at work <input checked="" type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <i>Wrens Creek</i>
20f. (City or town) <i>Hager</i>		(County) <i>Howard</i> (State) <i>MD</i>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE <i>E. Linkhardt</i>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <i>E. Linkhardt</i>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
DEPUTY MEDICAL EXAMINER <input type="checkbox"/>		<i>11/11/56</i>	
22a. FUNERAL CREMATION, REMOVAL (Specify) <i>Cremation</i>		22b. DATE THEREOF <i>11-19-56</i>	
22c. NAME OF CEMETERY OR CREMATORIAL <i>Our Lady of the Field</i>		22d. LOCATION (City, town, or county) <i>Millersville, Md.</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>William Reese, Jr. Annapolis, Md.</i>		ADDRESS <i>111 W. 20th St. Annapolis, Md.</i>	
24a. REG'D BY REGISTRAR <i>John G. Senay</i>		DATE <i>Nov. 20, 1956</i>	
24b. REGISTRAR'S SIGNATURE <i>John G. Senay</i>			

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10902

10905 CERTIFICATE OF DEATH

Reg. Dist. No. 21

1. PLACE OF DEATH a. COUNTY Anne Arundel		2. USUAL RESIDENCE (Where deceased lived if institution Residence before admission) a. STATE Maryland b. COUNTY Anne Arundel	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Annapolis		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Annapolis	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Homewood Conv. Home		d. STREET ADDRESS 59 Amos Garrett Blvd.	
e. IS RESIDENCE ON A FARM YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)	First DANIEL	Middle H	Last DAVIS
4. DATE OF DEATH	Month NOVEMBER	Day 18	Year 1956
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH March 25, 1884
9. AGE (In years lost birthday) 72 yrs.	10. IF UNDER 1 YEAR Months 0	11. IF UNDER 24 HRS Days 0	12. IF UNDER 24 HRS Hours 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Motorman		10b. KIND OF BUSINESS OR INDUSTRY Elect. R.R.	
11. BIRTHPLACE (State or foreign country) Riva, Maryland		12. CITIZEN OF WHAT COUNTRY/ USA	
13. FATHER'S NAME Daniel K. David		14. MOTHER'S MAIDEN NAME Mildred Redmond	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO 219-16-2440	
17. INFORMANT Mr. Channing H. Davis, Son - same as # 2		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY, IMMEDIATE CAUSE (a) 420.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) DUE TO (c)			
INTERVAL BETWEEN ONSET AND DEATH 1 Month			
Part II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Hour a. p.m. p.m.	Month, Day, Year 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)
21. I certify that I attended the deceased from APRIL , 19 56 , to 18 NOV 1956 , that I last saw the deceased alive on 18 Nov 1956 , and that death occurred at 10:55 AM , from the causes and on the date stated above ADDRESS (Street, city or town, state) 41 Southgate Ave. Annapolis, Maryland DATE SIGNED 11/19/56			
ACTUAL SIGNATURE Edward S. Beck		M.D.	
PHYSICIAN'S NAME (Type) Edward S. Beck MD		41 Southgate Ave. Annapolis, Maryland	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 11-20-56	22c. NAME OF CEMETERY OR CREMATORIUM St. Anne's Cemetery	22d. LOCATION (City, town, or county) Annapolis, Maryland (State)
23. FUNERAL DIRECTOR'S SIGNATURE Hopping Funeral Home		24a. REC'D BY REGISTRAR U. Ormond 24b. REGISTRAR'S SIGNATURE	
VS A15 (4) 15M 9/55			

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HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, it should be detached for use as the burial-trust permit. Then please remove carbon papers. Pages 2 and 3 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours of the death.

VS A15 (4)
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10906 CERTIFICATE OF DEATH

10912
(10912)

Reg. Dist. No.
51

1. PLACE OF DEATH a. COUNTY ANNE ARUNDEL		2. USUAL RESIDENCE (Where deceased lived) If institution: Residence before admission a. STATE MARYLAND				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) ANNAPOLIS		c. LENGTH OF STAY IN lb 7 days				
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION ANNE ARUNDEL GEN. HOSP.		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Susby				
d. STREET ADDRESS		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print)	First VIRGIL	Middle DAWKINS	4. DATE OF DEATH NOV. 8, 1956			
5. SEX Male	6. COLOR OR RACE Colored	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Mar 10, 1910			
9. AGE (In years lost birthday) 76 yrs	10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Labor	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) Maryland			
12. CITIZEN OF WHAT COUNTRY? U.S.A.	13. FATHER'S NAME William Dawkins					
14. MOTHER'S MAIDEN NAME Mary Ann Johnson			15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No			
16. SOCIAL SECURITY NO 217-01-380			17. INFORMANT Rosetta Dawkins			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) DUE TO GENERALIZED PERITONITIS			INTERVAL BETWEEN ONSET AND DEATH 11 days			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (o) DIABETES MELLITUS			19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				
20c. TIME OF INJURY Month, Day, Year Hour o. p.m. p. m. 19		20d. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 98 Cathedral St.	20f. (City or town) Baltimore	(County) Maryland	(State) Maryland
21. I certify that I attended the deceased from 11-1- , 1956, to 11-8- , 1956, that I last saw the deceased alive on 11-8-1956 , and that death occurred at 3:10 P.M. from the causes and on the date stated above. ACTUAL SIGNATURE Jesse L. Wilkins M.D. ADDRESS (Street, city or town, state) 98 Cathedral St. Baltimore, Maryland DATE SIGNED 11-8-56						
22a. BURIAL/CREMATION, REMOVAL (Specify) CREMATION		22b. DATE THEREOF 11-11-56	22c. NAME OF CEMETERY OR CREMATORIAL St. John's	22d. LOCATION (City, town, or county) Calvert (State) Maryland		
23. FUNERAL DIRECTOR'S SIGNATURE P.E. Howell		ADDRESS Prince Frederick	24a. REC'D BY REGISTRAR DATE 11/11/56	24b. REGISTRAR'S SIGNATURE Frank J. Harro		

1120

1120

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be filed with the registrar within 24 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 24 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 155 10A

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

10903 CERTIFICATE OF DEATH

10913

Reg. Dist. No.

1. PLACE OF DEATH		2. USUAL RESIDENCE (HOME) OF DECEASED	
COUNTY CITY (If outside corporate limits, write RURAL OR and give nearest town) TOWN	MARYLAND LENGTH OF STAY (In this place)	STATE CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN	COUNTY Maryland Anne Arundel
Anne Arundel Annapolis, Md. 7th. District Rescue Squad Ambulance	Minutes	STREET ADDRESS	(If rural give location)
3. NAME OF DECEASED (Type or Print)		4. DATE OF DEATH	
Baby Boy		Dean	Nov. 20 1956
5. SEX Male	6. COLOR OR RACE White	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Single	8. DATE OF BIRTH 20 November 1956
9. AGE last birthday yrs. 1	10. KIND OF BUSINESS OR INDUSTRY Infant	11. BIRTHPLACE (State or foreign country) Maryland	12. CITIZEN OF WHAT COUNTRY? U.S.
13. FATHER'S NAME Edward Thomas Dean		14. MOTHER'S MAIDEN NAME Betty Leona McCuen	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) No		16. SOCIAL SECURITY NO. None	
17. INFORMANT & ADDRESS Betty McCuen Dean		18. MEDICAL CERTIFICATION	
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH			
IMMEDIATE CAUSE <i>Initial respiratory failure</i> (A)			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (B) <i>Prematurity</i>			
DUE TO (C)			
II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.			
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		INTERVAL BETWEEN ONSET AND DEATH 1 hour	
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)	
21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)		21d. TIME OF INJURY (Month) (Day) (Year) (Hour) M. et work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
21e. INJURY OCCURRED While <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from 20 Nov. 1956, to 20 Nov. 1956, that I last saw the deceased alive on 20 Nov. 1956, and that death occurred at 9:30 p.m. from the causes and on the date stated above. SIGNATURE <i>Hendrick</i> M.D. Shady Side, Md. DATE SIGNED <i>21 Nov. 56</i> ADDRESS (Street, city, town, state)			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>Burial</i>		DATE THEREOF <i>11/23/56</i>	NAME OF CEMETERY OR CREMATORIAL <i>PRIVATE</i>
24. REC'D BY REGISTRAR REGISTRAR'S SIGNATURE <i>John M. G. & Sons Annapolis, Md.</i>		LOCATION (City, town, or county) <i>Annapolis Neck, Md.</i>	
DATE <i>2000232 XVO</i>		25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS	

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REGAL

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

10914

1099 CERTIFICATE OF DEATH

Reg. Dist. No.

INSTRUCTIONS TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this time it may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the attending physician and completely filled in by the attending physician and completely filled in by the funeral director, the third copy of this death certificate should be detached for use as a burial transit permit.		within 24 hours after death.										
1. PLACE OF DEATH COUNTY Anne Arundel CITY (If outside corporate limits, write RURAL OR TOWN give nearest town) Annapolis HOSPITAL OR INSTITUTION OR STREET ADDRESS 916 Spa Road					2. USUAL RESIDENCE (HOME) OF DECEASED MARYLAND Maryland CITY (If outside corporate limits, write RURAL and give nearest town) TOWN Annapolis STREET ADDRESS (If rural give location) 916 Spa Road							
3. NAME OF DECEASED (First) MARTHA (Middle) ERIN (Type or Print)					4. DATE OF DEATH November 25, 1950							
5. SEX Female	6. COLOR OR RACE Colored	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) Married	8. DATE OF BIRTH Jan 10, 1928	9. AGE last birthday 58 yrs.	10. IF UNDER 1 YEAR Months	11. IF UNDER 24 HRS. Days	12. Hours	13. Min				
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Domestic			10b. KIND OF BUSINESS OR INDUSTRY None			11. BIRTHPLACE (State or foreign country) Davidsonville, Maryland			12. CITIZEN OF WHAT COUNTRY?			
13. FATHER'S NAME James Edward Smith					14. MOTHER'S MAIDEN NAME Caroline Pratt							
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)			16. SOCIAL SECURITY NO. None			17. INFORMANT & ADDRESS Sylvia Vick's Union, 17-45 North Street, Baltimore, Md.						
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH IMMEDIATE CAUSE (A) Metastatic Carcinoma ANTECEDENT CAUSE(S) DUE TO Carcinoma of Breast DISEASES OR CONDITIONS, IF ANY, (B) GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C)										18. MEDICAL CERTIFICATION INTERVAL BETWEEN ONSET AND DEATH about 4 yrs		
II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.												
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION								20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)			21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)							
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED M. While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>			21f. HOW DID INJURY OCCUR?							
22. I hereby certify that I attended the deceased from 11-16-56 to 11-26-56, that I last saw the deceased alive on 11-25-56 at 19 , and that death occurred at 5:30 P.M. from the causes and on the date stated above. SIGNATURE <i>J. Allen</i> M.D. <i>62 Collier St</i> ADDRESS (Street, city, town, state) <i>West St. Union, Md.</i> DATE SIGNED <i>11-26-56</i>												
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>Burial</i>		DATE THEREOF Nov. 28, 1956		NAME OF CEMETERY OR CREMATORIUM Tower Hill Cemetery			LOCATION (City, town, or county) West St. Union, Md.			(State)		
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE <i>J. Allen - J. French</i>		25. FUNERAL DIRECTOR'S SIGNATURE <i>Sylvia Vick's Union, 17-45 North Street, Baltimore, Md.</i>			ADDRESS					
DATE												

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
10909 CERTIFICATE OF DEATH

10915
21

Reg. Dist. No.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 2 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 24 hours after death.

1. PLACE OF DEATH a. COUNTY Anne Arundel MARYLAND				2. USUAL RESIDENCE (Where deceased lived if institution Residence before admission) a. STATE Maryland b. COUNTY Anne Arundel			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Annapolis		c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Annapolis			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Truxton Hgts.				d. STREET ADDRESS Truxton Hgts			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) JUAN		FIRST MIDDLE SPIRITU	LAST	4. DATE OF DEATH NOVEMBER 11	Month	Day	Year 1956
5. SEX Male Philippine		6. COLOR OR RACE Philippine	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Feb. 11, 1911	9. AGE (In years less birthday) 45 yrs	IF UNDER 1 YEAR IF UNDER 24 HRS Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Cook		10b. KIND OF BUSINESS OR INDUSTRY Private Yacht		11. BIRTHPLACE (State or foreign country) Philippine Islands		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Unknown				14. MOTHER'S MAIDEN NAME Unknown			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 219-184919		17. INFORMANT Mrs Anna E. Espiritu- Wife- Same as # 2		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Acute pulmonary edema</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <i>P</i> DUE TO (c) <i>(D.O.A.)</i>				INTERVAL BETWEEN ONSET AND DEATH <i>31 hrs</i> <i>61 mon</i>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from _____, 19_____, to _____, 19_____, that I last saw the deceased alive on _____, 19_____, and that death occurred at <i>3A</i> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) <i>63 College Ave. Annapolis, Md.</i> DATE SIGNED <i>11/15/56</i>							
ACTUAL SIGNATURE <i>Frank M. Shipley</i>		M.D.					
PHYSICIAN'S NAME (Type) Frank M. Shipley MD							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Nov 13, 1956		22c. NAME OF CEMETERY OR CREMATORIUM St. Mary's Cemetery		22d. LOCATION (City, town, or county) (State) Annapolis Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE <i>Hopping Funeral Home</i>		ADDRESS <i>Annapolis, Md.</i>		24a. REC'D BY REGISTRAR <i>J. J. Donnelly</i>		24b. REGISTRAR'S SIGNATURE <i>J. J. Donnelly</i>	
				DATE <i>11/15/56</i>			

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INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. After this time, the bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this time, the certificate has been executed by the attending physician and completely filled in, it may be filed in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-35 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

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10916

10936 CERTIFICATE OF DEATH

Reg. Dist. No. 74

1. PLACE OF DEATH		2. USUAL RESIDENCE (HOME) OF DECEASED	
COUNTY CITY, (If outside corporate limits, write RURAL OR TOWN)	ANNE ARUNDEL GLEN BURME	MARYLAND LENGTH OF STAY (In this place)	STATE Maryland COUNTY CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Baltimore
HOSPITAL OR INSTITUTION OR STREET ADDRESS	PLAZA MANOR CONV. HOME		
3. NAME OF DECEASED (Type or Print)		4. DATE (Month) (Day) (Year)	
(First) FRANK (Middle) W. (Last) FISHER		NOV 14 1956	
5. SEX M	6. COLOR OR RACE C	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Widowed	8. DATE OF BIRTH
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Chauffuer		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) Virginia		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Moses Fisher		14. MOTHER'S MAIDEN NAME Ella Montague	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.)		16. SOCIAL SECURITY NO.	
(If Yes, give war or dates of service)		17. INFORMANT & ADDRESS - Mrs. Obelia Smith Rosedale St. 1913	
8. MEDICAL CERTIFICATION <i>METASTASES GENERALIZED OF CARCINOMA OF The LARYNX</i>			
INTERVAL BETWEEN ONSET AND DEATH			
10c. IMMEDIATE CAUSE (A)		DUE TO	
ANTECEDENT CAUSE(S) DUE TO		DISEASES OR CONDITIONS, IF ANY, (B)	
DISEASES OR CONDITIONS, IF ANY, (B)		GIVING RISE TO THE ABOVE CAUSE DUE TO	
STATING UNDERLYING CAUSE LAST. DUE TO		(C)	
11. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.			
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH <input type="checkbox"/> (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)	
21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED M. <input type="checkbox"/> at work <input type="checkbox"/> Not while <input type="checkbox"/> at work	
21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <i>May 1956</i> to <i>Nov 1956</i> , that I last saw the deceased alive on <i>Nov 1, 1956</i> , and that death occurred <i>10:30 P.M.</i> from the causes and on the date stated above. SIGNATURE <i>Joseph T. Fisher</i> ADDRESS (Street, city, town, state) <i>103 BALTO-ANNAP. BLVD. N.E. Bldg. 6</i> DATE SIGNED <i>11/11/56</i>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		DATE THEREOF 11-17-56	NAME OF CEMETERY OR CREMATORIAL Mt. Auburn Cem
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE <i>L. J. DeLille</i>	LOCATION (City, town, or county) Baltimore, Md.
DATE <i>11-17-56</i>		25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <i>Jesse E. Biddle / Biddle Corp.</i>	

CONFIDENTIAL

GEN

ALL INFORMATION CONTAINED

HEREIN

NOV 20 1956

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VII A15C 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

10917

10937 CERTIFICATE OF DEATH

Reg. Dist. No. ... 21

1. PLACE OF DEATH

COUNTY

CITY (If outside corporate limits, write RURAL
OR and give nearest town)

TOWN

HOSPITAL OR
INSTITUTION OR
STREET ADDRESS

MARYLAND

LENGTH OF STAY
(In this place)

14 mos

2. USUAL RESIDENCE (HOME) OF DECEASED

STATE

COUNTY

MD

CITY (If outside corporate limits, write RURAL and give nearest town)

TOWN

STREET
ADDRESS

(If rural give location)

Box 271-Route 1-Severna Park

**3. NAME OF
DECEASED
(Type or Print)**

(First)

(Middle)

(Last)

5. SEX

F

**6. COLOR OR
RACE**

W.

**7. SINGLE, MARRIED,
WIDOWED, DIVORCED,
(Specify)**

S.

8. DATE OF BIRTH

Feb 4, 1873

83 yrs.

vrs.

9. AGE last birthday

12 months

0 days

0 hours

0 minutes

**10. USUAL OCCUPATION (Give kind of work
done during most of working life, even if
retired)**

CLERK

**11. KIND OF BUSINESS
OR INDUSTRY**

Paint Factory

12. BIRTHPLACE (State or foreign country)

BALTC.

13. FATHER'S NAME

John Frederick

14. MOTHER'S MAIDEN NAME

Gruenewald

I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH**IMMEDIATE CAUSE**

(A)

Coronary Thrombosis

ANTECEDENT CAUSE(S)

(B)

DISEASES OR CONDITIONS, IF ANY,

(B)

GIVING RISE TO THE ABOVE CAUSE

(C)

STATING UNDERLYING CAUSE LAST, DUE TO

(C)

15. WAS DECEASED EVER IN U. S. ARMED FORCES?

(Yes, No, or unk.) (If Yes, give war or dates of service)

No

16. SOCIAL SECURITY NO.

215-07-3507

17. INFORMANT & ADDRESS

Margaret Irene Severna Park

18. MEDICAL CERTIFICATION

Generalized Arteriosclerosis

**INTERVAL BETWEEN
ONSET AND DEATH**

15 yrs

2 yrs

**II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING DEATH.****19a. DATE OF OPERATION****19b. MAJOR FINDINGS OF OPERATION****20. AUTOPSY?**YES NO **21a. ACCIDENT WAS UNDERLYING
OR CONTRIBUTING CAUSE OF DEATH
(If either, NOTIFY MEDICAL EXAMINER)****21b. PLACE (Home, farm, factory,
OF INJURY street, office bldg., etc.)****21c. WHERE DID INJURY OCCUR? (City or town)**

(County) (State)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)**21e. INJURY OCCURRED
M. While at work Not while
at work** **21f. HOW DID INJURY OCCUR?****22. I hereby certify that I attended the deceased from....., 19 S.J., to Nov 18, 1956, that I last saw the deceased**

alive on Oct 24, 1956, and that death occurred at 8 A.M. from the causes and on the date stated above.

SIGNATURE

R. J. Tolson M.D.

ADDRESS (Street, city, town, state)

DATE SIGNED

**23. BURIAL, CREMATION,
REMOVAL (SPECIFY)****24. REC'D BY REGISTRAR****DATE****25. FUNERAL-DIRECTOR'S SIGNATURE****ADDRESS****26. REGISTRAR'S SIGNATURE****DATE****27. FURNITURE****ADDRESS**

Y. A. U. I.

1956 2 V. N.

REFEVIEW

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10910 CERTIFICATE OF DEATH

10918

Reg. Dist. No.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 & 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <i>Anne Arundel</i>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution, Residence before admission) a. STATE <i>Maryland</i>		b. COUNTY <i>Anne Arundel</i>				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Annapolis</i>		c. LENGTH OF STAY IN lb		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Annapolis</i>		d. STREET ADDRESS <i>713 Warren Drive</i>				
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Anne Arundel General Hosp.</i>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>						
3. NAME OF DECEASED (Type or print)		First <i>Mary</i>	Middle <i>Elizabeth</i>	Last <i>Fulton</i>	4. DATE OF DEATH	Month <i>November</i>	Day <i>9</i>	Year <i>1956</i>		
5. SEX <i>Female</i>		6. COLOR OR RACE <i>White</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>May 24, 1867</i>		9. AGE (In years to nearest birthday) yrs <i>89</i>	10. IF UNDER 1 YEAR Months <i>0</i>	11. IF UNDER 24 HRS Days <i>0</i>	12. IF UNDER 24 HRS Hours <i>0</i>	13. IF UNDER 24 HRS Min. <i>0</i>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Own Home</i>		11. BIRTHPLACE (State or foreign country) <i>New York</i>		12. CITIZEN OF WHAT COUNTRY? <i>USA</i>				
13. FATHER'S NAME <i>Jeremiah Hall</i>		14. MOTHER'S MAIDEN NAME <i>Catherine Masterson</i>								
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>		16. SOCIAL SECURITY NO.		17. INFORMANT		Address <i>GEORGE Fulton #2</i>				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Alzheimer's disease cerebral vascular deg</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. <i>422.1</i> (b) DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH <i>5 years</i>				
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <i>Cataract both eyes, tumor in abdomen.</i>						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> TO CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part II or Part II of item 18.) <i>Oct. 1956 to Nov. 9, 1956, that I last saw the deceased alive on Oct. 8th, 1956, and that death occurred at 1:30 P.M., from the causes and on the date stated above.</i>								
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <i>45 Franklin St. Annapolis</i>		20f. (City or town) <i>Annapolis</i>		(County) <i>Anne Arundel</i>	(State) <i>M.D.</i>	
21. I certify that I attended the deceased from _____ to _____, that I last saw the deceased alive on _____, and that death occurred at _____, from the causes and on the date stated above. ACTUAL SIGNATURE <i>Zelma Proeller</i>						ADDRESS (Street, city or town, state) <i>45 Franklin St. Annapolis</i>		DATE SIGNED <i>Oct. 1956</i>		
PHYSICIAN'S NAME (Type) <i>EDITH RODLER M.D.</i>		M.D.								
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		22b. DATE THEREOF <i>11-12-1956</i>		22c. NAME OF CEMETERY OR CREMATORIUM <i>Evergreen Cemetery</i>		22d. LOCATION (City, town, or county) <i>New Brunswick N.J.</i>		(State) <i>N.J.</i>		
22e. FUNERAL DIRECTOR'S SIGNATURE <i>John D. Taylor & Sons Annapolis, Md.</i>		ADDRESS <i>John D. Taylor & Sons Annapolis, Md.</i>		24a. REC'D BY REGISTRAR <i>J. J. Smith</i>		24b. REGISTRAR'S SIGNATURE <i>J. J. Smith</i>				

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10938 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

10919
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Reg. Dist. No.

TO MUNICIPAL DIRECTOR: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with farm PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial/transit permit. File pages 1 and 2 with the registrar, prior to burial, cremation, or removal.

1. PLACE OF DEATH a. COUNTY Anne Arundel		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Maryland		b. COUNTY Anne Arundel					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) (Beverly Beach) Mayo		c. LENGTH OF STAY IN lb		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Mayo		d. STREET ADDRESS Beverly Beach					
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)						e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print)		First Dr. Vincent	Middle Gould	Last Lest	4. DATE OF DEATH Month November	Month 7	Day 19	Year 56			
5. SEX Male		6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH January 15, 1900	9. AGE (in years from birthday) 58 yrs.	IF UNDER 1 YEAR Months 0	IF UNDER 24 HRS. Days 0	Hours 0	Min. 0		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Physician		10b. KIND OF BUSINESS OR INDUSTRY General practice		11. BIRTHPLACE (State or foreign country) Canada		12. CITIZEN OF WHAT COUNTRY? USA					
13. FATHER'S NAME Unknown		14. MOTHER'S MAIDEN NAME Edith MacLeod									
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. no		17. INFORMANT Mrs. Helen H. Gould-Wife		Address Arundel Apts. Apt 12 A.					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY, IMMEDIATE CAUSE (a) 4343 DUE TO Conditions, if any, which gave rise to immediate cause (b) (a), stealing the underlying cause lost. DUE TO (c)											
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)											
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Natural causes								19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20c. TIME OF INJURY Month, Day, Year Hour 7:30 p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Mayo, Anne Arundel, Maryland		20f. (City or town) Mayo		(County) Anne Arundel		(State) Maryland	
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .											
ACTUAL SIGNATURE <i>Elmer G. Linhardt</i>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		DATE SIGNED November 9, 1956			
EXAMINER'S NAME (Type) Elmer G. Linhardt M.D.		22b. DATE THEREOF Nov. 12, 56		22c. NAME OF CEMETERY OR CREMATORIAL REMOVAL (Specify) Fort Lincoln Crematory		22d. LOCATION (City, town, or county) Prince George County, Maryland		(State)			
23. FUNERAL DIRECTOR'S SIGNATURE <i>Hopping Funeral Home</i>		ADDRESS Annapolis, Md.		24a. REG'D BY REGISTRAR Mrs. Carrie Sutton		24b. REGISTRAR'S SIGNATURE <i>Mrs. Carrie Sutton</i>					

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10939 CERTIFICATE OF DEATH

10920
34

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Anne Arundel		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland		b. COUNTY Anne Arundel		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Glen Burnie		c. LENGTH OF STAY IN lb 50 yrs.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Glen Burnie		d. STREET ADDRESS 609 Crain Highway, S.E.		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 609 Crain Highway, S.E.				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print) ALBERT		First	Middle	Los	DATE OF DEATH	Month	Day	Year
4. SEX Male		6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	B DATE OF BIRTH May 17, 1860	9. AGE (In years last birthday) 96	IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Canvas Seller		10b. KIND OF BUSINESS OR INDUSTRY Self Employed		11. BIRTHPLACE (State or foreign country) Baltimore, Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.		
13. FATHER'S NAME William A. Hamlen		14. MOTHER'S MAIDEN NAME Josephine Hiskey						
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yrs. no. or unknown) no		16. SOCIAL SECURITY NO. none		17. INFORMANT Mrs. Esther Greenwell		Address Glen Burnie, Md.		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) U 16.7		<i>Aortic Valve Insufficiency of Heart</i>				INTERVAL BETWEEN ONSET AND DEATH 5 days		
Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. Cardio-Vascular Disease		(b)				10 years		
DUE TO U 16.7		(c)						
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)						
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) Baltimore, Md.	(County)	(State)
21. I certify that I attended the deceased from _____, 19____, to _____, 19____, that I last saw the deceased alive on _____, 19____, and that death occurred at _____, 19____, M, from the causes and on the date stated above. ACTUAL SIGNATURE James S. Billingslee M.D. ADDRESS (Street, city or town, state) 108 Central St. Glen Burnie, Md. DATE SIGNED Dec. 1/1916								
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Dec. 3/56		22c. NAME OF CEMETERY OR CREMATORIAL Meadowridge Mem. Pk.		22d. LOCATION (City, town, or county) Howard Co., Maryland		
23. FUNERAL DIRECTOR'S SIGNATURE: Tichard V. Langston - Glen Burnie, Md.		ADDRESS		24a. REC'D BY REGISTRAR DATE		24b. REGISTRAR'S SIGNATURE L. J. Hellberg		

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10921

10911 CERTIFICATE OF DEATH

Reg. Dist. No.

21

1. PLACE OF DEATH a. COUNTY Anne Arundel MARYLAND			2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE MARYLAND b. COUNTY ANNE ARUNDEL		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Annapolis		c. LENGTH OF STAY IN 16 5 days	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) ANNAPOLIS		d. STREET ADDRESS 1000 Madison St.
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION U.S. Naval Hospital, Annapolis, Md.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)	First Stephen	Middle Craig	Last HAMMER	4. DATE OF DEATH Month November Day 14 Year 1956	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>	8. DATE OF BIRTH 9 November 1956	9. AGE (In years lost birthday) yrs 5	10. IF UNDER 1 YEAR Months 5 Days Hours 00 Min. 00
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) ---		10b. KIND OF BUSINESS OR INDUSTRY ---	11. BIRTHPLACE (State or foreign country) Maryland	12. CITIZEN OF WHAT COUNTRY? US	
13. FATHER'S NAME Roland James HAMMER			14. MOTHER'S MAIDEN NAME Patricia Elaine JETT		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. ---	17. INFORMANT U.S. Naval Hospital, Annapolis, Maryland	Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Postnatal asphyxia and atelectasis DUE TO with Immaturity #762.5				INTERVAL BETWEEN ONSET AND DEATH 5 days	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c)					
Part II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.	20d. INJURY OCCURRED White Not white at work <input type="checkbox"/> at work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) Annapolis	(County)	(State)
21. I certify that I attended the deceased from 13 November 1956, to 14 November 1956, that I last saw the deceased alive on 14 November 1956, and that death occurred at 0805 AM M, from the causes and on the date stated above.					
ACTUAL SIGNATURE	ADDRESS (Street, city or town, state)				DATE SIGNED 14 Nov. 1956
PHYSICIAN'S NAME (Type)	Francesco LE FAOLA LT MC USNR U.S. Naval Hospital, Annapolis Md.				
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF Nov. 15, 56	22c. NAME OF CEMETERY OR CREMATORIAL Naval Cemetery	22d. LOCATION (City, town, or county) (State) Annapolis, Md.		
23. FUNERAL DIRECTOR'S SIGNATURE Hopping Funeral Home	ADDRESS Annapolis, Md.	24a. REC'D BY REGISTRAR 24b. REGISTRAR'S SIGNATURE John D. Hopping			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, it should be filed with page 3, which should be detached for use as the burial-transit permit. Fill in page 3 to remove carbon papers. Pages 1 & 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU Y.

OCT 19 1956

REGISTRY

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
10912 CERTIFICATE OF DEATH

10923

Reg. Dist. No. 21

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE	
<i>Anne Arundel Maryland</i>		<i>Maryland Anne Arundel</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)	c. LENGTH OF STAY IN 1b	b. COUNTY	
<i>Annapolis</i>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		
<i>200 South 7th St. Annapolis, Md.</i>	<i>Annapolis</i>		
e. STREET ADDRESS	d. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print)	First	Middle	Last
<i>Male Col.</i>	<i>T</i>	<i>S</i>	<i>Hawkins</i>
4. DATE OF DEATH	Month	Day	Year
<i>6-30-79</i>	<i>6</i>	<i>25</i>	<i>1956</i>
5. SEX	6. COLOR OR RACE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH
<i>Male Col.</i>			<i>6-30-79</i>
9. AGE (in years last birthday) yrs.	10. IF UNDER 1 YEAR IF UNDER 24 HRS		
<i>77</i>	Months Days Hours Min		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)
<i>House Man</i>		<i>Hotel</i>	<i>Calvert Co. Md.</i>
12. CITIZEN OF WHAT COUNTRY?		<i>U.S.A.</i>	
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME	
<i>Henry Hawkins</i>		<i>Louise Kent</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Type, no, or unknown) If yes, give war or dates of service)		16. SOCIA. SECURITY NO	17. INFORMANT
<i>No</i>		<i>202-27-3197A</i>	<i>Cassie Hawkins - Annapolis, Md.</i>
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]		Address	
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)		<i>Pneum Carcinoma</i>	
180x		DUE TO	INTERVAL BETWEEN ONSET AND DEATH
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.		(b)	
		DUE TO	
		(c)	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)
19			
21. I certify that I attended the deceased from <i>9-65-56</i> , 19 to <i>11-25-79</i> , 19, that I last saw the deceased alive on <i>11-24-56</i> , 19, and that death occurred at <i>Baptist</i> M. from the causes and on the date stated above.		ADDRESS (Street, city or town, state) <i>42 Cathedral St</i> DATE SIGNED	
ACTUAL SIGNATURE <i>E.T. Allen</i>		M.D.	
PHYSICIAN'S NAME (Type) <i>A T ALLEN</i>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		22b. DATE THEREOF <i>11-29-56</i>	22c. NAME OF CEMETERY OR CREMATORIUM <i>Brewer Field</i>
			22d. LOCATION (City, town, or county) <i>Annapolis</i> (State) <i>Md.</i>
23. FUNERAL DIRECTOR'S SIGNATURE <i>William Glese II - Annapolis, Md.</i>		24a. REG'D BY REGISTRAR <i>Nov. 27, 1956</i> 24b. REGISTRAR'S SIGNATURE <i>J. French</i>	
		DATE	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, it should be detached for use as the burial permit. Then please remove carbon paper. Pages 1 & 2 should be filed with the registrar prior to a burial, cremation, or removal, and in any event within 72 hours after death.

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REAU V. A.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
1094 CERTIFICATE OF DEATH

12050
 28

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Anne Arundel		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE MARYLAND	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Crownsville		c. LENGTH OF STAY IN 1b 2yrs. 3mos. 4days	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Crownsville State Hospital		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore City	
3. NAME OF DECEASED (Type or print) William		First William	Middle
4. DATE OF DEATH Last Henderson	Month 11	Doy 6	Year 1956
5. SEX Male	6. COLOR OR RACE Negro	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Not given
9. AGE (In years last birthday) 75	10. IF UNDER 1 YEAR Months -	11. IF UNDER 24 HRS. Days -	12. IF UNDER 24 HRS. Hours -
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer	10b. KIND OF BUSINESS OR INDUSTRY Unknown	11. BIRTHPLACE (State or foreign country) Maryland	12. CITIZEN OF WHAT COUNTRY? U.S.
13. FATHER'S NAME Unknown		14. MOTHER'S MAIDEN NAME Unknown	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 	17. INFORMANT Hospital Records
		Address State Hospital Crownsville, Maryland	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinoma of left jaw		INTERVAL BETWEEN ONSET AND DEATH 4 months	
196X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause lost. (b) DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Aortic insufficiency, Senile Arteriosclerosis		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from 10/17 , 19 56 , to 11/6 , 19 56 , that I last saw the deceased alive on 11/5 , 19 56 , and that death occurred at 11:05 P.M. , from the causes and on the date stated above. ACTUAL SIGNATURE <i>Lionel McHenry Mapp</i> PHYSICIAN'S NAME (Type) Lionel McHenry Mapp			
22a. CEMETERY, CREMATION, OR REMOVAL (Specify) Baltimore	22b. DATE THEREOF 11-20-56	22c. NAME OF CEMETERY OR CREMATORIAL 71st St. of Md. Medgill Baltimore	22d. LOCATION (City, town, or county) md.
23. FUNERAL DIRECTOR'S SIGNATURE <i>William Race, II - Annapolis, MD</i>	ADDRESS 	24a. REC'D. BY REGISTRAR DATE 17 1956	24b. REGISTRAR'S SIGNATURE

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4
 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director,
 page 4 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 4 and 2 should be filed with
 the registrar prior to burial, cremation, or removal, and in any event within 24 hours after death.

BUREAU V. S.

JULY - 1956

REGISTRATION

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10942 CERTIFICATE OF DEATH

10924 *28*

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Anne Arundel		MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland		b. COUNTY Baltimore City		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Crownsville		c. LENGTH OF STAY IN lb 2yr. 9mos. 17days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore City				
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Crownsville State Hospital		d. STREET ADDRESS 914 N. Gilmore		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print)	First Elizabeth	Middle Ann	Last Holland	4. DATE OF DEATH 11	Month 11	Day 26	Year 1956	
5. SEX Female	6. COLOR OR RACE Negro	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>	8. DATE OF BIRTH 1881?	9. AGE (In years last birthday) 75? yrs	IF UNDER 1 YEAR Months —	IF UNDER 24 HRS Days —	Hours —	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Cook		10b. KIND OF BUSINESS OR INDUSTRY — — —		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U. S.		
13. FATHER'S NAME John Holland		14. MOTHER'S MAIDEN NAME Mariah Holland						
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.		17. INFORMANT Hospital Records		Crownsville State Hospital Crownsville, Maryland		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Congestive Heart Failure <i>420.</i>		DUE TO (b) Arteriosclerotic Heart Disease		DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH		
Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last.								
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Carcinoma of right breast						19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)						
20c. TIME OF INJURY Hour o. s. p. m.		Month, Day, Year 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) Crownsville, Maryland	(County)	(State)	
21. I certify that I attended the deceased from alive on 11/25 , 19 56 ,		2/9, 19 54, to 11/26, 19 56,	that I last saw the deceased and that death occurred at 9:10a.m., from the causes and on the date stated above. ADDRESS (Street, city or town, state) Crownsville, Maryland					
ACTUAL SIGNATURE <i>Ludwig Benedict</i>		DATE SIGNED 11/26/56						
PHYSICIAN'S NAME (Type) Ludwig Benedict, M. D.								
22a. BURIAL, CREMATION, REMOVAL (Specify) 4/29/56		22b. DATE THEREOF 12/11	22c. NAME OF CEMETERY OR CREMATORIAL Mt. Calvary		22d. LOCATION (City, town, or county) Baltimore	(State) Md.		
23. FUNERAL DIRECTOR'S SIGNATURE <i>Virgil B. Ruggold</i>		ADDRESS 1463 N. Carey St.	24a. REC'D BY REGISTRAR DATE		24b. REGISTRAR'S SIGNATURE <i>K. M. Joyce</i>			

RECEIVED

OCT 29 1956

RECEIVED

10940 CERTIFICATE OF DEATH

Reg. Dist. No. 74

INSTRUCTIONS.

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

1. PLACE OF DEATH		2. USUAL RESIDENCE (HOME) OF DECEASED	
COUNTY CITY (If outside corporate limits, write RURAL OR end give nearest town) TOWN HOSPITAL OR INSTITUTION OR STREET ADDRESS	Anne Arundel Maryland Riverdale Norwich Rd.	LENGTH OF STAY (in this place)	STATE CITY (If outside corporate limits, write RURAL and give nearest town) TOWN STREET ADDRESS
3. NAME OF DECEASED (Type or Print)		4. DATE (Month) (Day) (Year) OF DEATH NOV 7 - 1956.	
5. SEX <input checked="" type="checkbox"/> M	6. COLOR OR RACE <input checked="" type="checkbox"/> W	7. SINGLE, MARRIED, W DIVD., DIVORCED. (Specify)	8. DATE OF BIRTH Jan 23, 1908 49 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY Landscape -	11. BIRTHPLACE (State or foreign country) BALTO.
13. FATHER'S NAME N. Earl Hopkins		14. MOTHER'S MAIDEN NAME Lillian Morris	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <input checked="" type="checkbox"/> Yes, w. #2. 214-03-2780		16. SOCIAL SECURITY NO. 17. INFORMANT & ADDRESS Daughter - Elyse Jane Hopkins Riverdale	
III DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH			
IMMEDIATE CAUSE <input checked="" type="checkbox"/>		(A) MYOCARDIAL INFARCTION	
ANTECEDENT CAUSE(S) DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.		(B) DUE TO (C) Generalized Arteriosclerosis	
IV OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.			
19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION		
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED M. While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
		21f. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from Sept 19, 1956, to Nov 1956, that I last saw the deceased alive on Nov 19, 1956, and that death occurred at 12 AM, from the causes and on the date stated above.			
SIGNATURE Robert R. Helms M.D.		ADDRESS (Street, city, town, state) Severna Park Md 11-7-56	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial	DATE THEREOF 11-9-56	NAME OF CEMETERY OR CREMATORIAL Balto. National Cem.	LOCATION (City, town, or county) Pattimore, Maryland
24. REC'D BY REGISTRAR DATE Nov 8 1956	REGISTRAR'S SIGNATURE J. J. Deibas	25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS Loring Byers, 5505 Park Hwy s. Av., Baltimore, Maryland	

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
10913 CERTIFICATE OF DEATH

Reg. Dist. No.

10925

1. PLACE OF DEATH a. COUNTY Anne Arundel MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Md b. COUNTY AA	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Annapolis, Md		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Annapolis, Md.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION U.S. Naval Hospital, Annapolis, Md.		d. STREET ADDRESS 144 Dewey Drive	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)	First Muriel	Middle Joan	Last Hubbard
4. DATE OF DEATH	Month 11	Day 11	Year 1956
S. SEX F	6. COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 11 November 1956
9. AGE (In years last birthday) yrs		10. IF UNDER 1 YEAR Months	11. IF UNDER 24 HRS. Days Hours Min
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME Ralph M. Hubbard		14. MOTHER'S MAIDEN NAME Kitty Mae Marshall	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO 17. INFORMANT U.S. Naval Records Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 1 No X DUE TO Conditions, If any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH 5 min.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)
21. I certify that I attended the deceased from 11-11-1956 to 11-11-56, that I last saw the deceased alive on 11-11-56, 19_____, and that death occurred at 5:30 P.M. from the causes and on the date stated above. ACTUAL SIGNATURE <u>Malcolm W. Mason</u> ADDRESS (Street, city or town, state) PHYSICIAN'S NAME (Type) M.A. MASON CAPT. MC USAF M.D. DATE SIGNED 11-12-56			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 11-12-56	22c. NAME OF CEMETERY OR CREMATORIAL St. Thomas
23. FUNERAL DIRECTOR'S SIGNATURE John M. Glass & Sons		ADDRESS Annapolis, Md.	24a. REC'D BY REGISTRAR DATE
VS AITS (4) 1SM 9/55		24b. REGISTRAR'S SIGNATURE	

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10943 CERTIFICATE OF DEATH

10926 *24*

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <i>Anne Arundel</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution, Residence before admission) a. STATE <i>Maryland</i> b. COUNTY <i>Anne Arundel</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Skidmore</i>	c. LENGTH OF STAY IN lb <i>1b</i>	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Skidmore</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>R.T.D. 2 Box 511</i>		e. STREET ADDRESS <i>R.T.D. 2 Box 511</i>	f. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) <i>Walter John Johnson</i>	First <i>Walter</i>	Middle <i>John</i>	Last <i>Johnson</i>
4. DATE OF DEATH <i>11/14/56</i>	Month <i>11</i>	Day <i>14</i>	Year <i>1956</i>
5. SEX <i>Male</i>	6. COLOR OR RACE <i>Col.</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>7-4-1885</i>
9. AGE (In years lost birthday) yrs <i>71</i>	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Handyman</i>	11. KIND OF BUSINESS OR INDUSTRY <i>U.S. Naval Acad.</i>	12. BIRTHPLACE (State or foreign country) <i>Skidmore, Md</i>
13. FATHER'S NAME <i>Nathan Johnson</i>	14. MOTHER'S MAIDEN NAME <i>Annie Johnson</i>	15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Type or print name) <i>No</i>	
16. SOCIAL SECURITY NO. <i>213-10-2032</i>		17. INFORMANT <i>Mary R. Johnson - Skidmore, Md.</i>	Address
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <i>Cerebral hemorrhage & pneumonia & cardiac</i>		INTERVAL BETWEEN ONSET AND DEATH <i>445 X</i>	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO (b) <i>Terminal disease Grade III</i>		} DUE TO (c) <i>2 months</i>	
Part II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <i>19</i>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <i>Skidmore</i>	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <i>Nov 13, 1956</i> to <i>Nov 14, 1956</i> that I last saw the deceased alive on <i>Nov 14, 1956</i> , and that death occurred at <i>Skidmore</i> M. from the causes and on the date stated above. ACTUAL SIGNATURE <i>A. R. Richardson</i> PHYSICIAN'S NAME (Type)			
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>	22b. DATE THEREOF <i>11-18-56</i>	22c. NAME OF CEMETERY OR CREMATORIUM <i>Broad Neck</i>	22d. LOCATION (City, town, or county) <i>Skidmore</i> md
23. FUNERAL DIRECTOR'S SIGNATURE <i>William Reese - Annapolis, Md.</i>	ADDRESS	24a. REC'D BY REGISTRAR <i>Jan 20 1956</i>	24b. REGISTRAR'S SIGNATURE <i>L. L. Bellinger</i>

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10927

10927 CERTIFICATE OF DEATH

Reg. Dist. No. 21

1. PLACE OF DEATH a. COUNTY Anne Arundel		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md.		b. COUNTY A. A.	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Annapolis		c. LENGTH OF STAY IN lb		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Glen Burnie		d. STREET ADDRESS 106 - 1st Ave., S. W.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Anne Arundel General Hosp.						e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)	First WALTER	Middle S.	Last JONES	4. DATE OF DEATH NOV. 11, 1956	Month NOV.	Day 11	Year 1956
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>	8. DATE OF BIRTH Oct. 7, 1878	9. AGE (In years lost birthday) 78 yrs.	10. IF UNDER 1 YEAR Months 0	11. IF UNDER 24 HRS. Days 0	12. Hours 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Clergyman (rtd)		10b. KIND OF BUSINESS OR INDUSTRY Methodist Church		11. BIRTHPLACE (State or foreign country) Md.		12. CITIZEN OF WHAT COUNTRY? Address Laura Virginia Laughton	
13. FATHER'S NAME J. Edwin Jones		14. MOTHER'S MAIDEN NAME					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) none		16. SOCIAL SECURITY NO. none		17. INFORMANT Miss Beulah Jones - 19 W. 29th St.		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Impaired Insufficiency DUE TO Coronary Thrombosis Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause lost Arteriosclerotic Heart Disease	
						INTERVAL BETWEEN ONSET AND DEATH 6 Hours	
						DUE TO 12 DAYS	
						DUE TO Unknown	
Part II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour o. ft. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 11/12 , 19 56 , to 11/14 , 19 56 that I last saw the deceased alive on 11/14 , 19 56 , and that death occurred at 10:20 A.M. from the causes and on the date stated above ADDRESS (Street, city or town, state) Edward S. Beck M.D. 41 Southgate Ave. Annapolis 11/14/56		DATE SIGNED					
ACTUAL SIGNATURE Edward S. Beck							
PHYSICIAN'S NAME (Type) EDWARD S. BECK, M.D.							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 11/17/56		22c. NAME OF CEMETERY OR CREMATORIUM Western Cem.		22d. LOCATION (City, town, or county) Baltimore, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Wm. J. Lickner & Sons - Baeto 17 Md		ADDRESS Wm. J. French		24a. REG'D BY REGISTRAR DATE Nov. 16, 1956		24b. REGISTRAR'S SIGNATURE Wm. J. French	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. It may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 4 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
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INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be retained by the funeral director as a burial transit permit.

VS AISC 155 FORM

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

1094 CERTIFICATE OF DEATH

10928

74

Reg. Dist. No.

1. PLACE OF DEATH		2. USUAL RESIDENCE (HOME) OF DECEASED	
COUNTY CITY (If outside corporate limits, write RURAL OR end give nearest town) TOWN	MARYLAND LENGTH OF STAY (In this place)	STATE CITY (Include corporate limits, write RURAL and give nearest town) OR TOWN	COUNTY MARYLAND STREET ADDRESS (Rural give location)
Anne Arundel Frost - Glen Burnie	2 yrs	Anne Arundel Frost - Glen Burnie	Pasadena P.O. Md
HOSPITAL INSTITUTION OR STREET ADDRESS	Bro 285 Rfd #1 Pasadena P.O. Md		
3. NAME OF DECEASED (Type or Print)		4. DATE (Month) (Day) (Year)	
(First) Leonore (Middle) Elton (Last) Kirby		Nov. 27 1956	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED, WIDOWED, DIVORCED, (Specify) Separated	8. DATE OF BIRTH Nov. 11, 1884
9. AGE last birthday 72	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife	11. KIND OF BUSINESS OR INDUSTRY Game	12. CITIZEN OF WHAT COUNTRY? Nova Scotia Dominion of Canada U.S.A.
13. FATHER'S NAME William Haight	14. MOTHER'S MAIDEN NAME Unknown	15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, No, or unk.) No	
16. SOCIAL SECURITY NO. None		17. INFORMANT & ADDRESS Winona Ryan - Bro 285, Rfd #1 Pasadena, Md	
II DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH			
42-1 IMMEDIATE CAUSE (A) Respiratory Failure			
ANTECEDENT CAUSE(S) DUE TO (B) Coronary Thrombosis 24 hr.			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (C) Hypertensive Heart Disease 26 hrs STATING UNDERLYING CAUSE LAST. DUE TO Generalized Atherosclerosis 5 yrs			
18. MEDICAL CERTIFICATION			
19a. DATE OF OPERATION			
19b. MAJOR FINDINGS OF OPERATION			
20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		INTERVAL BETWEEN ONSET AND DEATH	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)	
21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) M.		21e. INJURY OCCURRED While Not while at work at work	
21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from 11/25-1956 to 11/27-1956, that I last saw the deceased alive on 11/27-1956, and that death occurred at 8 P.M. from the causes and on the date stated above. SIGNATURE Q.W. Richard M.D. 715 Calter Rd. Glen Burnie 11/27-1956 ADDRESS (Street, city, town, or county) Winsor Mill Rd. Balt. Co. Md. DATE SIGNED 11/27-1956			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		DATE THEREOF 11-30-1956	NAME OF CEMETERY OR CREMATORIUM Lorraine Cemetery
24. REC'D. BY REGISTRAR		REGISTRAR'S SIGNATURE L. J. Schlesinger	
DATE Nov. 29, 1956		25. FUNERAL DIRECTOR'S SIGNATURE George J. Ruth Inc. - 1735 Harford Avenue ADDRESS Baltimore, Md.	



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10929

10945 CERTIFICATE OF DEATH

Reg. Dist. No. 24

1. PLACE OF DEATH a. COUNTY <i>Anne Arundel</i>		2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE <i>Md.</i>						
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Baltimore, Md.</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Baltimore</i>						
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>133 C lifton Ave.</i>		d. STREET ADDRESS <i>919 W. Barre St.</i>						
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>								
3. NAME OF DECEASED (Type or print)	First <i>HENRY</i>	Middle <i>August</i>	Last Jr. <i>Kummer</i>					
4. DATE OF DEATH	Month <i>11</i>	Day <i>14</i>	Year <i>1956</i>					
5. SEX <i>M</i>	6. COLOR OR RACE <i>W</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>7-18-1883</i>					
9. AGE (In years last birthday) <i>76 yrs.</i>	10. IF UNDER 1 YEAR Months <i>0</i>	11. IF UNDER 24 HRS. Days <i>0</i>	12. IF UNDER 24 HRS. Hours <i>0</i>					
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Retired Brakeman Railroad</i>	10b. KIND OF BUSINESS OR INDUSTRY <i>Railroad</i>	11. BIRTHPLACE (State or foreign country) <i>Baltimore Md</i>	12. CITIZEN OF WHAT COUNTRY? <i>U.S.</i>					
13. FATHER'S NAME <i>HENRY August Kummer</i>	14. MOTHER'S MAIDEN NAME <i>Ida. Escatemian</i>							
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>	16. SOCIAL SECURITY NO. <i>—</i>	17. INFORMANT <i>Daughter (Mrs J. Lang Arnold Md)</i>	Address <i>Belvedere 1136</i>					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>CARCINOMA</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>CARCINOMA RECTUM</i> DUE TO (c)								
Part II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			INTERVAL BETWEEN ONSET AND DEATH <i>1 year</i>					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)						
20c. TIME OF INJURY Hour a. m. p. m.	Month <i>July</i>	Day <i>19</i>	Year <i>1956</i>	20d. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <i>—</i>	20f. (City or town) <i>—</i>	(County) <i>—</i>	(State) <i>—</i>
21. I certify that I attended the deceased from <i>July 1956</i> , to <i>11-14-1956</i> that I last saw the deceased alive on <i>11-12 1956</i> , and that death occurred at <i>10 P.M.</i> from the causes and on the date stated above.								
ACTUAL SIGNATURE <i>Francis J. Codd</i>	ADDRESS (Street, city or town, state) <i>SEVERNA PARK MD</i>			DATE SIGNED <i>11-14-56</i>				
PHYSICIAN'S NAME (Type) <i>Francis J. Codd</i>								
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>	22b. DATE THEREOF <i>11/19/56</i>	22c. NAME OF CEMETERY OR CREMATORIUM <i>Western Cem.</i>	22d. LOCATION (City, town, or county) <i>Baltimore, Md.</i>	(State)				
23. FUNERAL DIRECTOR'S SIGNATURE <i>J.W. Schuster & Sons - Balt 17 Md</i>	ADDRESS <i>—</i>	24a. REC'D BY REGISTRAR <i>11-14-56</i>	24b. REGISTRAR'S SIGNATURE <i>J. Schuster</i>					

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, it should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10915 CERTIFICATE OF DEATH

Reg. Dist. No.

10930
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1. PLACE OF DEATH a. COUNTY Anne Arundel		MARYLAND		2. USUAL RESIDENCE (Where deceased lived if institution; Residence before admission) a. STATE Maryland		b. COUNTY Anne Arundel		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Annapolis, Md.		c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Annapolis		d. STREET ADDRESS 47 Franklin Street		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 47 Franklin Street				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print) Maurice		First C	Middle Legum	Last L	4. DATE OF DEATH November 11,	Month 11	Day 19	Year 56
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH July 29, 1885	9. AGE (In years last birthday) 71 yr.	10. IF UNDER 1 YEAR Months 0	11. IF UNDER 24 HRS Days 0	Hours 0	Min. 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Ret. Proprietor		10b. KIND OF BUSINESS OR INDUSTRY Liquor Store		11. BIRTHPLACE (State or foreign country) Lithuania		12. CITIZEN OF WHAT COUNTRY? USA		
13. FATHER'S NAME Unknown				14. MOTHER'S MAIDEN NAME Unknown				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 217-14-5890		17. INFORMANT Eva Legum- Wife- same as # 2		Address		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. coronary artery disease		arteriosclerotic heart disease				INTERVAL BETWEEN ONSET AND DEATH 4 years		
DUE TO gen. arterio sclerosis								
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)								
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>								
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)						
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that I attended the deceased from 7-1 , 19 52 to 11-11 , 19 56 , that I last saw the deceased alive on 11-11-56 , 19 56 , and that death occurred at 13rd St. M. , from the causes and on the date stated above. ACTUAL SIGNATURE Edith Roodler M.D.		ADDRESS (Street, city or town, state) 45 Franklin Street, Annapolis, Md. DATE SIGNED						
PHYSICIAN'S NAME (Type) Edith Roodler		45 Franklin Street, Annapolis, Md.						
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Nov. 12, 1956		22c. NAME OF CEMETERY OR CREMATORIUM Knesseth Israel Cemetery		22d. LOCATION (City, town, or county) Annapolis, Maryland (State)		
23. FUNERAL DIRECTOR'S SIGNATURE HOPPING FUNERAL HOME		ADDRESS Annapolis, Md.		24a. REC'D BY REGISTRAR DATE		24b. REGISTRAR'S SIGNATURE		

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10945

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

10945

TO DEPUTY MEDICAL EXAMINER: This certificate should be examined within 24 hours after death. If any delay is necessary, please excuse the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 is to be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your records.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation or removal.

1. PLACE OF DEATH a. COUNTY Anne Arundel		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Same	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Glen Burnie		c. LENGTH OF STAY IN 1b 2 years	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 600 First Ave., Marwood		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF (Type or print) Georges Wayne Lewis		First Georges	Middle Wayne
4. DATE OF DEATH November 1st, 1956	Month November	Day 1st	Year 1956
5. SEX M	6. COLOR OR RACE W	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 5/31/16
9. AGE (In years last birthday) 40 yrs.		10. IF UNDER 1 YEAR Months 0	11. IF UNDER 24 HRS. Hours 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Concrete Worker		11. BIRTHPLACE (State or foreign country) Virginia	
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME William D. Lewis	
14. MOTHER'S MAIDEN NAME Aldie Davis		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <input checked="" type="checkbox"/> Navy	
16. SOCIAL SECURITY NO. 186-07-8735		17. INFORMANT Mrs. Dorothy Lewis (wife) Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Occlusion DUE TO Ido. I ? Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Peptic Ulcer DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.			
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1b.)			
20c. TIME OF INJURY Hour o. m. p. m.	Month, Day, Year 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE <i>Gustave H. Faubert, M.D.</i>	M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		
EXAMINER'S NAME (Type) Gustave H. Faubert, M.D.	DATE SIGNED 11/2/156		
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 11/5/56	22c. NAME OF CEMETERY OR CREMATORIUM Balto. National	22d. LOCATION (City, town, or county) Baltimore, Md. (State)
23. FUNERAL DIRECTOR'S SIGNATURE McCully Funeral Home 130 E. Fort Ave. #30	ADDRESS McCully Funeral Home 130 E. Fort Ave. #30	24a. REC'D BY REGISTRAR 11/5/156	24b. REGISTRAR'S SIGNATURE L. J. Deallas

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10932
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10947 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Anne Arundel MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY AA	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Lombardee Beach		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Lombardee Beach Solley, Md.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Rt. 1 Box 202 Lombardee Beach		e. STREET ADDRESS Lombardee Beach Rd.	
3. NAME OF DECEASED (Type or print) Ralph		First Samuel	Middle Lynn
4. DATE OF DEATH 11	Month 15	Day 19	Year 56
5. SEX M	6. COLOR OR RACE W	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 1/27/91
9. AGE (In years last birthday) 62 yrs.		10. IF UNDER 1 YEAR Months	11. IF UNDER 24 HRS Days Hours Min
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Checker		10b. KIND OF BUSINESS OR INDUSTRY Atlantic Term.	
10c. BIRTHPLACE (State or foreign country) Phil., Pa.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Alexander Lynn		14. MOTHER'S MAIDEN NAME Mary Schlutter	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 17. INFORMANT Family	
		Address Same	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Bronchogenic carcinoma</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO (c) _____			
INTERVAL BETWEEN ONSET AND DEATH 2 years			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>10/4/51</u> , to <u>11/15/56</u> , that I last saw the deceased alive on <u>11/13/56</u> , and that death occurred at <u>5:00 A.M.</u> from the causes and on the date stated above. ACTUAL SIGNATURE <u>J. Brady Smith</u> M.D. ADDRESS (Street, city or town, state) <u>Riviera Beach, Md</u> DATE SIGNED <u>11/16/56</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 11/17/56	22c. NAME OF CEMETERY OR CREMATORIUM Cedar Hill Cem.
22d. LOCATION (City, town, or county) Baltimore, Md.		(State)	
23. FUNERAL DIRECTOR'S SIGNATURE McCully Funeral Home		ADDRESS 130 E. Fort Ave. #30	24a. REC'D BY REGISTRAR DATE NOV 19 1956
		24b. REGISTRAR'S SIGNATURE <u>L. J. Deallay</u>	

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10933

Reg. Dist. No. 21

10910 CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY Anne Arundel		MARYLAND		2. USUAL RESIDENCE (Where deceased lived if institution Residence before admission) a. STATE Maryland		b. COUNTY Anne Arundel	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Annapolis		c. LENGTH OF STAY IN 1b 16		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Annapolis		d. STREET ADDRESS 54 Southgate Ave.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Anne Arundel General Hospital				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) ESTHER		First	Middle MANDELSTAN	4. DATE OF DEATH NOVEMBER 16 1956	Month	Doy	Year
5. SEX Female		6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>	8. DATE OF BIRTH October 6, 1879	9. AGE (In years last birthday) 77 yrs	10. IF UNDER 1 YEAR Months	11. IF UNDER 24 HRS. Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House wife		10b. KIND OF BUSINESS OR INDUSTRY own home		11. BIRTHPLACE (State or foreign country) Lithuania		12. CITIZEN OF WHAT COUNTRY USA	
13. FATHER'S NAME Louis Kaplan		14. MOTHER'S MAIDEN NAME Tobie Benjamin					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. none		17. INFORMANT Mrs Louis M. Strauss-Daughter - same as # 2		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute myocardial infarction						INTERVAL BETWEEN ONSET AND DEATH 11 hrs	
Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last.		DUE TO (b) After onset of the cardiac trouble disease				20 yrs	
DUE TO (c)							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. n. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 11/16 , 1956, to 11/16 , 1956, that I last saw the deceased alive on 11/16 , 1956, and that death occurred at 8:25 M, from the causes and on the date stated above.						ADDRESS (Street, city or town, state) Hagerstown, Maryland	
ACTUAL SIGNATURE John Hedeman		M.D.				DATE SIGNED 11/17/56	
PHYSICIAN'S NAME (Type) John Hedeman		MD		90 Cathedral Street		Annapolis, Md.	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 11-18-56		22c. NAME OF CEMETERY OR CREMATORIUM B'nai Abraham Cemetery		22d. LOCATION (City, town, or county) Hagerstown, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE HOPPING FUNERAL HOME		ADDRESS Annapolis, Maryland		24a. REC'D BY REGISTRAR J. H. Hopping		24b. REGISTRAR'S SIGNATURE J. H. Hopping	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4

may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, it should be filed with the funeral director.
page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. page 2 should be filed with the register prior to burial, cremation, or removal, and in any event within 72 hours of death.

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10934

10948 CERTIFICATE OF DEATH

Reg. Dist. No.

28

1. PLACE OF DEATH a. COUNTY Anne Arundel County		MARYLAND		2. USUAL RESIDENCE (Where deceased lived if institution, Residence before admission) a. STATE Maryland		b. COUNTY Baltimore City		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Crownsville		c. LENGTH OF STAY IN 1B 10½ months		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore City				
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Crownsville State Hospital		d. STREET ADDRESS 460 Oxford Court		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print) Ronald		First	Middle	Last	4. DATE OF DEATH 11	Month	Day	Year
5. SEX Male		6. COLOR OR RACE colored	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>	B. DATE OF BIRTH 10/6/48	9. AGE (in years last birthday) 8 yrs	10. IF UNDER 1 YEAR Months	11. IF UNDER 24 HRS Days	Hours
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U. S.		
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME Katrina Massdin						
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.		17. INFORMANT		Address Crownsville State Hospital, Md.		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 441X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last } (b) Paraplegia		Purulent Bronchiolitis bilaterally				INTERVAL BETWEEN ONSET AND DEATH one week		
DUE TO { c) Chronic Brain Syndrome associated with Convulsive Disorder								
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)						19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 1b)		none				
20c. TIME OF INJURY Month, Day, Year Hour a. m. _____ 19 p. m. _____		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) _____ (County) _____		(State) _____
21. I certify that I attended the deceased from Nov. 30, 1956, that I last saw the deceased alive on Nov. 30, 1956, and that death occurred at 3:35 P.M., from the causes and on the date stated above. ACTUAL SIGNATURE <i>Ludwig Benedict</i>						DATE SIGNED _____ ADDRESS (Street, city or town, state) Crownsville State Hospital, Md.		
PHYSICIAN'S NAME (Type) Ludwig Benedict, M. D.		Crownsville, Md.		12/1/56				
22a. BURIAL / CREMATION, REMOVAL (Specify) Dec. 4-56 Mt. Auburn Cemetery		22b. DATE THEREOF 1956		22c. NAME OF CEMETERY OR CREMATORIAL Crownsville, Md.		22d. LOCATION (City, town, or county) Baltimore		(State) Md.
23. FUNERAL DIRECTOR'S SIGNATURE <i>François Henry, 578 W. Brodale</i>		ADDRESS 187		24a. RECEIVED BY REGISTRAR Dec. 3, 1956		24b. REGISTRAR'S SIGNATURE <i>R. M. Joyce</i>		

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10935

10949 CERTIFICATE OF DEATH

Reg. Dist. No. 28

1. PLACE OF DEATH a. COUNTY Anne Arundel		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Maryland		b. COUNTY Baltimore City		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Crownsville		c. LENGTH OF STAY IN 1b 14 days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore City				
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Crownsville State Hospital		d. STREET ADDRESS 1210 McElderry Court		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print)	First Irene	Middle McCrory	Last McCrary	4. DATE OF DEATH 11 16 19 56	Month 11	Day 16	Year 19 56	
5. SEX Female	6. COLOR OR RACE Negro	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH S.C. 30 yrs.	9. AGE (In years last birthday) 30 yrs.	10. IF UNDER 1 YEAR Months 0	11. IF UNDER 24 HRS Days 0	12. IF UNDER 24 HRS Hours 0	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Home		11. BIRTHPLACE (State or foreign country) S.C.		12. CITIZEN OF WHAT COUNTRY? Crownsville, Md.		
13. FATHER'S NAME Richard Padden		14. MOTHER'S MAIDEN NAME Ella Padden		Address Crownsville State Hospital				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO 000-00-0000		17. INFORMANT Hospital Records		INTERVAL BETWEEN ONSET AND DEATH		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pyelonephritis with Uremia DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 600.0 (b) DUE TO (c)								
Part II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Hypertensive Cardiovascular Disease, Syphilis								
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)						19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20c. TIME OF INJURY Hour a. p.m.	Month 19	Day 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) Crownsville, Md.	(County) Crownsville, Md.	(State) Md.	
21. I certify that I attended the deceased from 11/3 1956 to 11/16 19 56 , that I last saw the deceased alive on 11/15 19 56 , and that death occurred at 9:30a. M., from the causes and on the date stated above.								
ADDRESS (Street, city or town, state) Crownsville, Md.								
DATE SIGNED 11/16/56								
MEDICAL CERTIFICATION								
I certify that this certificate has been signed by the attending physician, and completely filled out by the funeral director. After this certificate has been signed by the attending physician and completely filled out by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.								
NAME (Type) Lionel McHenry Mapp								
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF Nov. 25, 1956	22c. NAME OF CEMETERY OR CREMATORIAL Baltimore Cemetery	22d. LOCATION (City, town, or county) Baltimore	(State) Md.				
23. FUNERAL DIRECTOR'S SIGNATURE G. E. J. Mapp	ADDRESS 1000 E. 36th St. Baltimore, Md.	24a. REC'D BY REGISTRAR 1138-56	24b. REGISTRAR'S SIGNATURE Hathurie M. Jayce					

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10936

Reg. Dist. No.

CERTIFICATE OF DEATH

10917

1. PLACE OF DEATH a. COUNTY <i>a.a.</i>		2. USUAL RESIDENCE (Where deceased lived - If institution: Residence before admission) b. STATE <i>MD</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Annapolis</i>		c. LENGTH OF STAY IN 1b <i>10 days</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) <i>St. Jeneral</i>		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Annapolis</i>	
3. NAME OF DECEASED (Type or print) <i>Eugenio M. Medford</i>		d. STREET ADDRESS <i>15 Locust Ave</i>	
5. SEX <i>Female</i>		6. COLOR OR RACE <i>White</i>	
7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		8. DATE OF BIRTH <i>3-12-1878</i>	
WIDOWED <input type="checkbox"/>		9. AGE (In years last birthday) <i>78 yrs.</i>	
DIVORCED <input type="checkbox"/>		10. IF UNDER 1 YEAR Months <i>11</i> Days <i>1</i> Hours <i>0</i> Min. <i>0</i>	
11. IF UNDER 24 HRS Months <i>0</i> Days <i>0</i> Hours <i>0</i> Min. <i>0</i>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>House wife</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Home</i>	
11. BIRTHPLACE (State or foreign country) <i>Catonsville, Baltimore Co., Md.</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	
13. FATHER'S NAME <i>John G. Fisher</i>		14. MOTHER'S MAIDEN NAME <i>Elenore Bennix</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Name, no. of unit, rank) <i>No</i>		16. SOCIAL SECURITY NO. <i>-</i>	
17. INFORMANT <i>Jesse L. Medford</i>		Address <i>2</i>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>163X</i> DUE TO Conditions, if any, which gave rise to immediate cause (a) (b) <i>Laserium of lung</i> DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <i>6 mos +</i>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20c. TIME OF INJURY Month, Day, Year Hour o. m. 19 p. m.		20d. INJURY OCCURRED White Nat white at work <input type="checkbox"/> at work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <i>8/12</i> , 19 <i>56</i> , to <i>11/1</i> , 19 <i>56</i> , that I last saw the deceased alive on <i>11/1</i> , 19 <i>56</i> , and that death occurred at <i>6:50 A.M.</i> from the causes and on the date stated above. ACTUAL SIGNATURE <i>Maurice Klawans M.D.</i>		ADDRESS (Street, city or town, state) <i>Annapolis, Md.</i> DATE SIGNED <i>11/1/56</i>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		22b. DATE THEREOF <i>11-5-1956</i>	
22c. NAME OF CEMETERY OR CREMATORIUM <i>Parkwood Cemt</i>		22d. LOCATION (City, town or county) <i>Baltimore</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>John M. Taylor</i>		24a. REC'D BY REGISTRAR DATE <i>11/56</i>	
24b. REGISTRAR'S SIGNATURE <i>J. French</i>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death; Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-tranit permit. Then please remove carbon papers. Pages 1, 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

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SERIALS SECTION

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10937
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CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH o COUNTY		10950 <i>Anne Arundel</i>	2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) o. STATE	MD. <i>A. A.</i>
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		c. LENGTH OF STAY IN 1b <i>Arnold. 36 yrs</i>	b. COUNTY	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		d. STREET ADDRESS <i>Dividing Cr. Rd.</i>	e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)		First <i>William Henry Moore</i>	Middle	Last
4. DATE OF DEATH		Month 11-12-56	Day	Year 19
5. SEX	6. COLOR OR RACE	7. MARRIED <input type="checkbox"/> NEVERMARRIED <input type="checkbox"/> DATE OF BIRTH WIDOWED <input type="checkbox"/> DIVORCED <i>Jan 28, 1875</i>	8. AGE (In years lost birthday), yrs.	9. IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)
<i>Store Keeper</i>		<i>Grocery</i>		<i>Chicago Ill. U.S.</i>
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME		12. CITIZEN OF WHAT COUNTRY? Address
<i>Herman Moore</i>		<i>W. Zimmerman</i>		<i>U.S.A.</i>
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>no</i>		16. SOCIAL SECURITY NO		17. INFORMANT <i>wife mrs moore - Arnold moore</i>
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>145 X</i>		DUE TO <i>Carcinoma Tonsil</i>		INTERVAL BETWEEN ONSET AND DEATH <i>1 yr.</i>
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (If you give the cause, state the underlying cause last.) (b) DUE TO (c)				
Part II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)				
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		
20c. TIME OF INJURY Month, Day, Year Hour o. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <i>1956</i> , 19, to <i>Nov 12</i> , 1956, that I last saw the deceased alive on <i>10 Nov 56</i> , 19, and that death occurred at <i>8:20 AM</i> , from the causes and on the date stated above. ACTUAL SIGNATURE <i>Robert R. Hahn MD.</i> ADDRESS (Street, city or town, state) NAME (Type) <i>Robert R. Hahn</i> DATE SIGNED <i>11-12-56</i>				
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 11-16-56	22c. NAME OF CEMETERY OR CREMATORIUM Western Cemetery	22d. LOCATION (City, town, or county) Baltimore (State)
23. FUNERAL DIRECTOR'S SIGNATURE William Cook, Inc., 1217 St. Paul Street		ADDRESS	24a. REC'D BY REGISTRAR DATE Nov. 14, 1956	24b. REGISTRAR'S SIGNATURE <i>L. J. Delaney</i>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

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TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for you.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation or removal.

Reg. Dist. No. 27

VS. AFMSE(5)
SM 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10951 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

10939

1. PLACE OF DEATH a. COUNTY Anne Arundel		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Md. b. COUNTY Baltimore				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Ft. Meade		c. LENGTH OF STAY IN lb 6 Hrs				
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Ft. Meade Hospital		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Arbutus, Baltimore 27.				
3. NAME OF DECEASED (Type or print) Frances		First Marion	Middle Neighoff			
Last ll		4. DATE OF DEATH Nov. 9	Month Nov. Day 9 Year 1956			
5. SEX Male		6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			
8. DATE OF BIRTH 7/4/07		9. AGE (In years last birthday) 49 yrs.				
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Plumber		10b. KIND OF BUSINESS OR INDUSTRY				
11. BIRTHPLACE (State or foreign country) Baltimore, Md.		12. CITIZEN OF WHAT COUNTRY? USA				
13. FATHER'S NAME Francis M. Neighoff ll		14. MOTHER'S MAIDEN NAME Elizabeth Schanken				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 7-316-1636				
17. INFORMANT Mrs Catherine Neighoff, same as 2		Address				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]						
PART I. DEATH WAS CAUSED BY, IMMEDIATE CAUSE (a) Coronary Occlusion						
DUE TO 480.1						
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b)						
DUE TO (c)						
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)						
				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				
20c. TIME OF INJURY Hour e. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) Baltimore	(County) Baltimore	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .						
ACTUAL SIGNATURE <i>Gustave H. Faubert M.D.</i>		DATE SIGNED Nov. 9, 1956				
EXAMINER'S NAME (Type) Gustave H. Faubert		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>				
22a. BURIAL, CREMATION, REMOVAL (Specify) Cremation		22b. DATE THEREOF Nov. 3, 1956		22c. NAME OF CEMETERY OR CREMATORIAL Landon Park		22d. LOCATION (City, town, or county) Baltimore
23. FUNERAL DIRECTOR'S SIGNATURE <i>Frederick A. Cole, 1913 W. Baltimore St.</i>		ADDRESS 1913 W. Baltimore St.		24a. REC'D BY REGISTRAR 10:15		24b. REGISTRAR'S SIGNATURE <i>J. M. Taylor</i>

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10952 CERTIFICATE OF DEATH

10940

Reg. Dist. No.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death; Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 & 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <i>West River</i>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution- Residence before admission) a. STATE <i>MD</i>		b. COUNTY <i>West River</i>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>West River</i>		c. LENGTH OF STAY IN 1b <i>1 yr</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>West River</i>				
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i></i>		d. STREET ADDRESS <i></i>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print)	First <i>HOWARD</i>	Middle <i>PEARKE</i>	Last <i></i>	4. DATE OF DEATH <i>Nov 4 1956</i>	Month <i>Nov</i>	Day <i>4</i>	Year <i>1956</i>	
5. SEX <i>Male</i>	6. COLOR OR RACE <i>White</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>Mar 15 1875</i>	9. AGE (in years last birthday) <i>81 yrs.</i>	10. IF UNDER 1 YEAR Months <i></i>	11. IF UNDER 24 HRS. Days <i></i>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Farmer</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Tobacco</i>		11. BIRTHPLACE (State or foreign country) <i>West River</i>		12. CITIZEN OF WHAT COUNTRY? <i>West River</i>		
13. FATHER'S NAME <i>Wm H Peake</i>		14. MOTHER'S MAIDEN NAME <i>Virginia Sanders</i>		Address <i>Mrs Mary Nutwell West River Md.</i>				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>		16. SOCIAL SECURITY NO. <i>—</i>		17. INFORMANT <i></i>		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Cancerous prostate c metastasis</i>		
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. <i></i>		(b) <i></i>		DUE TO <i></i>		INTERVAL BETWEEN ONSET AND DEATH <i>1 year.</i>		
DUE TO <i></i>		(c) <i></i>						
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)						
20c. TIME OF INJURY Hour a. m. p. m. <i>19</i>	Month <i></i>	Day <i></i>	Year <i></i>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <i></i>	20f. (City or town) <i></i>	(County) <i></i>	(State) <i></i>
21. I certify that I attended the deceased from <i>October 1956</i> to <i>Nov 4 1956</i> , and that death occurred at <i>12:30 PM</i> , from the causes and on the date stated above. ACTUAL SIGNATURE <i>Howard Peake</i>		ADDRESS (Street, city or town, state) <i></i>		DATE SIGNED <i>1956</i>				
PHYSICIAN'S NAME (Type) <i>Howard Peake M.D.</i>								
22a. BURIAL, CREMATON, REMOVAL (Specify) <i>Burial</i>	22b. DATE THEREOF <i>Nov 6 1956</i>	22c. NAME OF CEMETERY OR CREMATORIUM <i>Christ Church</i>	22d. LOCATION (City, town, or county) <i>West River</i>		(State) <i>MD</i>			
23. FUNERAL DIRECTOR'S SIGNATURE <i>Bernard Hardisty Elizaville Md.</i>		ADDRESS <i></i>	24a. REC'D BY REGISTRAR DATE <i></i>		24b. REGISTRAR'S SIGNATURE <i></i>			

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10941

10918 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <i>A A</i>		2. USUAL RESIDENCE (Where deceased lived if institution Residence before admission) a. STATE <i>Md</i> b. COUNTY <i>A A</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>AnneArundel</i>	c. LENGTH OF STAY IN 1b <i>3 days</i>	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Desle</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>AnneArundel General</i>		d. STREET ADDRESS	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)	First <i>DELMA</i>	Middle <i>VIRGINIA</i>	Last <i>Phipps</i>
4. DATE OF DEATH	Month <i>Nov</i>	Day <i>11</i>	Year <i>1956</i>
5. SEX <i>Female</i>	6. COLOR OR RACE <i>White</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH <i>3/13/11</i>
9. AGE (In years last birthday) <i>45 yrs</i>		10. IF UNDER 1 YEAR Months <i>0</i>	11. IF UNDER 24 HRS Days <i>0</i>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <i>Chorlton Md</i>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <i>Loy Bland Phipps</i>		14. MOTHER'S MAIDEN NAME <i>Clora Delma Rogers</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>		16. SOCIAL SECURITY NO <i>none</i>	
17. INFORMANT <i>Rewitt Phipps Desle, Md</i>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Cerebral Thrombosis</i>		INTERVAL BETWEEN ONSET AND DEATH <i>2 days</i>	
DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <i>Cerebral Arteriosclerosis</i>		INTERVAL UNKNOWN	
DUE TO (c) <i>Arteriosclerosis, Galloping</i>		INTERVAL UNKNOWN	
Part II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <i>Arteriosclerosis, Myocardial Insufficiency</i>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <i>None</i>	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <i>19</i>		20d. INJURY OCCURRED White of work <input type="checkbox"/> Not white of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) <i>Desle</i> (State) <i>Md</i>	
21. I certify that I attended the deceased from <i>11/11/1956</i> to <i>11/11/1956</i> that I last saw the deceased alive on <i>11/11/1956</i> , and that death occurred at <i>5:30 A.M.</i> from the causes and on the date stated above.			
ACTUAL SIGNATURE <i>Edward S. Beck</i>		ADDRESS (Street, city or town, state) <i>44 Southgate Ave, Annapolis Md</i>	
PHYSICIAN'S NAME (Type) <i>Edward S. Beck MD</i>		DATE SIGNED <i>11/13/56</i>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		22b. DATE THEREOF <i>11/13/56</i>	
22c. NAME OF CEMETERY OR CREMATORIUM <i>Zucker</i>		22d. LOCATION (City, town, or county) <i>Annapolis</i> (State) <i>Md</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>Bernard Hardisty Galveston Md</i>		24a. REC'D BY REGISTRAR DATE <i>10-0-1956</i>	
		24b. REGISTRAR'S SIGNATURE <i>John W. Smith</i>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 14 hours after death. Page 2 should be filed with the funeral director.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10942

CERTIFICATE OF DEATH

Reg. Dist. No. 21

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4
may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, it may be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <i>AGNE FRONDEL MARYLAND</i>		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) b. STATE <i>SEVERNA PARK MD</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>HANNAH POLIS MD</i>		c. LENGTH OF STAY IN lb <i>15 days</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>AGNE FRONDEL</i>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <i>MARIE PORTER</i>		First	Middle
		Last	4. DATE OF DEATH <i>11 18 1956</i>
5. SEX <i>FEMALE</i>	6. COLOR OR RACE <i>WIDOWED</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>10/16/1893</i>
9. AGE (In years from birthdate) <i>63 yrs</i>		10. IF UNDER 1 YEAR Months <i>1</i>	11. IF UNDER 24 HRS Days <i>2</i>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>HOUSE WIFE</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>NEW JERSEY</i>	
10c. BIRTHPLACE (State or foreign country) <i>NEW JERSEY</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	
13. FATHER'S NAME <i>NOT KNOWN</i>		14. MOTHER'S MAIDEN NAME <i>NOT KNOWN</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>		16. SOCIAL SECURITY NO. <i>MRS AGNES DAILEY NORTHWAG</i>	
17. INFORMANT <i>LAWRENCE CHASE</i>		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Congestive Heart Failure, Ankle Swelling</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <i>Hypertensive Arteriosclerotic Heart Disease</i> DUE TO (c) <i>4 yrs</i>	
19. INTERVAL BETWEEN ONSET AND DEATH. <i>1 week</i>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) <i>No</i>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18) <i>Chronic</i>	
20c. TIME OF INJURY Hour a. p.m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <i>Severna Park MD</i>		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <i>JAN.</i> , 19 <i>56</i> , to <i>19<i>56</i></i> , that I last saw the deceased alive on <i>11-17-19<i>56</i></i> , and that death occurred at <i>3rd Fl M</i> , from the causes and on the date stated above. ACTUAL SIGNATURE <i>Fannie L. Codd</i> M.D. ADDRESS (Street, city or town, state) <i>Severna Park MD</i> DATE SIGNED <i>11-18-19<i>56</i></i>			
22a. PHYSICIAN'S NAME (Type) <i>Dr. Wm French</i>		22b. DATE THEREOF <i>11/21/56</i>	
22c. NAME OF CEMETERY OR CREMATORIAL <i>Baltimore Crematory</i>		22d. LOCATION (City, town, or county) (State) <i>Baltimore Crematory</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>John J. French</i>		24a. REC'D BY REGISTRAR DATE <i>11-21-56</i>	
		24b. REGISTRAR'S SIGNATURE <i>Dr. Wm French</i>	

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10953 CERTIFICATE OF DEATH

10943

Reg. Dist. No.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death; Page 4 may be signed by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, it should be filed with page 3, and be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY Anne Arundel		MARYLAND		2 USUAL RESIDENCE (Where deceased lived if institution Residence before admission) a. STATE Maryland		b. COUNTY Baltimore City		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Crownsville		c. LENGTH OF STAY IN lb		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore City				
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Crownsville State Hospital				d. STREET ADDRESS 528 N. Carrollton Avenue		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) Viola		First	Middle	Last	4. DATE OF DEATH Randolph	Month 11	Day 27	Year 19 56
5. SEX Female	6. COLOR OR RACE Negro	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 9/20/93		9. AGE (In years lost birthday) 63 yrs.	10. IF UNDER 1 YEAR OR IF UNDER 24 HRS Months — Days Hours Min.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Waitress		10b. KIND OF BUSINESS OR INDUSTRY Unk.		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U. S.		
13. FATHER'S NAME John Randolph		14. MOTHER'S MAIDEN NAME Annie Randolph						
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or date of service)		16. SOCIAL SECURITY NO.		17. INFORMANT Hospital Records		Crownsville State Hospital Crownsville, Maryland		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)						Address		
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)		Acute renal failure				INTERVAL BETWEEN ONSET AND DEATH		
446 X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.		(b) Arteriosclerotic Hypertensive Disease						
(c)								
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		Hepatomegaly with Ascites				19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)						
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that I attended the deceased from 11/24 , 19 56 , to 11/27 , 19 56 , that I last saw the deceased alive on 11/26 , 19 56 . And that death occurred at 2:55 A.M. from the causes and on the date stated above						ADDRESS (Street, city or town, state)		
ACTUAL SIGNATURE <i>Lionel McHenry Mapp</i>				M.D.		DATE SIGNED 11/27/56		
PHYSICIAN'S NAME (Type) Lionel McHenry Mapp								
22a. BURIAL, CREMATION, REMOVAL (Specify) 1/16/56		22b. DATE THEREOF 1/16/56		22c. NAME OF CEMETERY OR CREMATORIUM Mt. Auburn		22d. LOCATION (City, town, or county) Baltimore Md. (State)		
23. FUNERAL DIRECTOR'S SIGNATURE <i>A. Halsted & Son Funeral Home</i>		ADDRESS 16 Halsted & 918 Dund Hollow		24a. REC'D BY REGISTRAR DATE 1/14/56		24b. REGISTRAR'S SIGNATURE <i>J. M. Hayes</i>		

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INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

10944

10951 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH		2. USUAL RESIDENCE (HOME) OF DECEASED	
COUNTY CITY (if outside corporate limits, write RURAL OR end give nearest town) TOWN	Anne Arundel MARYLAND Pasadena MD 2 yrs. Ritchie Highway Pasadena Md.	STATE CITY (if outside corporate limits, write RURAL and give nearest town) OR TOWN	MD COUNTY A.A Pasadena MD Ritchie Highway.
HOSPITAL OR INSTITUTION OR STREET ADDRESS	(First) (Middle) (Last)	STREET ADDRESS	(If rural give location)
3. NAME OF DECEASED (Type or Print)		4. DATE OF DEATH	
Mattie K. Reich		Nov. 6. 1956	
5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH
F.	W.	Widowed	Nov 27, 1883
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	
Housewife		House	
13. FATHER'S NAME		11. BIRTHPLACE (State or foreign country)	
Thomas P. West		Baltimore County	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.)		16. SOCIAL SECURITY NO.	
(If Yes, give war or dates of service)		17. INFORMANT & ADDRESS	
18. MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH	
IMMEDIATE CAUSE ANTECEDENT CAUSE(S) DUE TO DISEASES OR CONDITIONS, IF ANY, (B) GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C)		Myocardial Infarction Generalized arteriosclerosis, severe Diabetes mellitus.	
19. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.			
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21a. INJURY OCCURRED M. at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
21c. WHERE DID INJURY OCCUR? (City or town)		(County) (State)	
21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from 1955, 19, to Nov., 1956, that I last saw the deceased alive on Nov. 20, 1956, and that death occurred at ... M, from the causes and on the date stated above.			
SIGNATURE		ADDRESS (Street, city, town, state)	
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		DATE THEREOF	
Burial		11/9/56 Good Shepherd	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE	
DATE		25. FUNERAL DIRECTOR'S SIGNATURE	
		ADDRESS	
		L. J. McAllister MacNabb & Son 28	

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INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: This law requires that the death certificate be executed within 24 hours after death.

TO FUNERAL DIRECTOR: The law requires that the death certificate be executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transcript.

V5 AISC 435 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, MD.**10955 CERTIFICATE OF DEATH**

10945

28

Reg. Dist. No.....

1. PLACE OF DEATH		2. USUAL RESIDENCE (HOME) OF DECEASED	
COUNTY CITY (If outside corporate limits, write RURAL OR TOWN)	Anne Arundel XXXXXX 5 wks.	MD LENGTH OF STAY (in this place)	STATE Maryland COUNTY Anne Arundel CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN
HOSPITAL OR INSTITUTION OR STREET ADDRESS	Millersville Sann's Nursing Home	STREET ADDRESS	416 Sixth Ave., N.E. (If rural give location)
3. NAME OF DECEASED (Type or Print)	(First) EDITH (Middle) SANNER (Last)	4. DATE (Month) (Day) (Year) OF DEATH November 26, 1956	
5. SEX Female	6. COLOR OR RACE White	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Single	8. DATE OF BIRTH Aug. 11, 1895
9. AGE last birthday 61 yrs.	10. KIND OF BUSINESS OR INDUSTRY Sec. (ret.) U.S.Civil Serv.	11. BIRTHPLACE (State or foreign country) St. Mary's County, Md.	12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME Richard B. Sanner	14. MOTHER'S MAIDEN NAME Nancy T. Jones		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) no	16. SOCIAL SECURITY NO. none	17. INFORMANT & ADDRESS Mr. Carroll Sanner Towson, Md	517 Park Ave.
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH			
IMMEDIATE CAUSE ANTECEDENT CAUSE(S) DUE TO DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO	18. MEDICAL CERTIFICATION Carcinoma Breast INTERVAL BETWEEN ONSET AND DEATH 11 mos		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.			
19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)	21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) M. at work <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>	21e. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>	21f. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from Sept. 19, 1956, to Nov. 19, 1956, that I last saw the deceased alive on Oct. 23, 1956, and that death occurred at 8:45 A.M. from the causes and on the date stated above.			
SIGNATURE <i>Carroll Sanner MD</i>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial	DATE THEREOF 11/29/56	NAME OF CEMETERY OR CREMATORIAL Woodlawn	ADDRESS (Street, city, town, state) Glen Burnie, Md
24. REC'D. BY REGISTRAR DATE	REGISTRAR'S SIGNATURE <i>D. M. Joyce</i>	25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS Reed Singleton - Glen Burnie, Md	

NEW YORK

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REGISTRATION

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

10946

10955 CERTIFICATE OF DEATH

Reg. Dist. No. 74

1. PLACE OF DEATH a. COUNTY		Anne Arundel MARYLAND		2. USUAL RESIDENCE (Where deceased lived if institution: Residence before admission) a. STATE		Md.		b. COUNTY		Anne Arundel	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		Severna Park		c. LENGTH OF STAY IN 1b		35 yrs		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		Severna Park Md	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		Cedar Rd - Carrollton Manor		d. STREET ADDRESS		Coronation Cedar Rd - Manor		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)		First	Middle	Last	4. DATE OF DEATH	Month	Day	Year			
M		W			20 Nov.	1956					
5. SEX		6. COLOR OR RACE		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/>		8. DATE OF BIRTH		9. AGE (in years last birthday)		IF UNDER 1 YEAR IF UNDER 24 HRS.	
M		W		Divorced <input type="checkbox"/>		Sept 5 - 1882 74 yrs		Months Days Hours Min		Months	Days
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?					
Painter		Boat repair		Anne Arundel County		U.S.					
13. FATHER'S NAME		Harmon Sappington		Anna Boozey		Severna Park		Addres			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown. If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]		INTERVAL BETWEEN ONSET AND DEATH			
NO		220-16-490		Severna Park		PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)		Cremated			
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.		DUE TO (b)		PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (b)		Atherosclerotic C. I. Disease					
DUE TO (c)											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)					
21. I certify that I attended the deceased from 1955, 19 Nov., 1956, that I last saw the deceased alive on Nov 19-56, and that death occurred at 8:30 AM, from the causes and on the date stated above.		ADDRESS (Street, city or town, state)		DATE SIGNED							
MEDICAL CERTIFICATION SIGNATURE		Robert R. Hahn M.D.		Severna Park 11-20-56							
PHYSICIAN'S NAME (Type)		Robert R. HAHN		Md.							
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORIUM		22d. LOCATION (City, town, or county)		(State)			
Burial		11/24/56		Cedar Hill		Balto. 25		Md.			
23. FUNERAL DIRECTOR'S SIGNATURE		ADDRESS		24a. REC'D BY REGISTRAR		24b. REGISTRAR'S SIGNATURE					
James E. Kirkley		Hopping and Kirkley, Glen Burnie, Md.		NOV 26 1956		L. J. de Alba					

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REGULATED

MARYLAND

STATE DEPARTMENT OF HEALTH

10947

10957 CERTIFICATE OF DEATH

Reg. Dist. No.....

1. PLACE OF DEATH: COUNTY <u>Anne Arundel</u>		2. USUAL RESIDENCE (HOME) OF DECEASED: STATE <u>MD</u>	
CITY (If outside corporate limits, write RURAL and OR give nearest town) TOWN <u>Arnold</u>		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Arnold</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Dividing Cr. Rd.</u>		STREET ADDRESS <u>Dividing Cr Rd.</u>	
3. NAME OF DECEASED (Type or Print)	(First) <u>Carrie</u>	(Middle) <u>T.</u>	(Last) <u>Schriener</u>
4. SEX <u>F.</u>	5. COLOR OR RACE <u>W</u>	6. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>MARRIED</u>	7. DATE OF BIRTH <u>1908-1875-81</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Home</u>	
11. BIRTHPLACE (State or foreign country) <u>Baltimore Md</u>		12. CITIZEN OF WHAT COUNTRY <u>A.S.</u>	
13. FATHER'S NAME <u>John</u>		14. MOTHER'S MAIDEN NAME <u>John</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>Div Gress Rd S.P.</u>	
17. INFORMANT AND ADDRESS <u>Daughter, Mrs. Bush.</u>			

MARGIN RESERVE FOR BINDING

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		18. MEDICAL CERTIFICATION	
Immediate cause <u>Acute Pulmonary Edema</u>		(a) <u>Arteriosclerotic C. V. Disease</u>	
Antecedent cause(s) <u></u>		(b) <u></u>	
Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (c) <u></u>			
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.			
19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY	
21. ACCIDENT SUICIDE HOMICIDE		PLACE (Home, farm, factory, street, OF office bldg., etc.)	(CITY OR TOWN)
TIME (Month) (Day) (Year) (Hour) OF INJURY		INJURY OCCURRED While at m. Work <input type="checkbox"/> At work <input type="checkbox"/>	(COUNTY)
		HOW DID INJURY OCCUR?	(STATE)

22. I hereby certify that I attended the deceased from <u>1955</u> , 19 <u>57</u> , to <u>Nov</u> , 19 <u>57</u> that I last saw the deceased alive on <u>Oct 10</u> , 19 <u>57</u> and that death occurred at <u>1:20 A.M.</u> from the causes and on the date stated above. SIGNATURE <u>Robert R. Hahn, M.D.</u> ADDRESS <u>Severna Park Md</u> DATE SIGNED <u>1957</u>			
23. BURIAL, CREMATION REMOVAL (Specify) <u>Burial</u>	DATE <u>11-12-56</u>	NAME OF CEMETERY OR CREMATORIAL <u>Bethesda Cemetery</u>	LOCATION (City, town, or county) <u>Baltimore Md</u> (State) <u>Md</u>
DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR ADDRESS <u>John M. Taylorson Annapolis Md</u>	

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MAP

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Items 5, 6, 7 F1.

10948

10958

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <i>None Arundel</i>) MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Maryland AA b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Shady Side</i>	c. LENGTH OF STAY IN 1b <i>83Y</i>	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Shady Side</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>None</i>	d. STREET ADDRESS —		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) <i>James Albert Scott</i>	First	Middle	Last
4. DATE OF DEATH <i>November 10 1956</i>	Month	Day	Year
5. SEX <i>Male</i>	6. COLOR OR RACE <i>Negro</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>DEC 9 1873</i>
9. AGE (In years last birthday) <i>83 yrs.</i>	10. IF UNDER 1 YEAR Months	11. IF UNDER 24 HRS. Days	12. IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Waterman</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Oyster</i>	
11. BIRTHPLACE (State or foreign country) <i>Shady Side</i>		12. CITIZEN OF WHAT COUNTRY? <i>USA</i>	
13. FATHER'S NAME <i>Jacob Scott</i>		14. MOTHER'S MAIDEN NAME <i>Matilda Thompsons</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>		16. SOCIAL SECURITY NO. <i>none</i>	
17. INFORMANT Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Heart failure Coronary Occlusion</i> 2 days DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause first. (b) <i>Arteriosclerosis.</i> DUE TO (c)			
INTERVAL BETWEEN ONSET AND DEATH <i>5 Years</i>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <i>Hypertension</i>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <i>—</i>	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <i>19</i> p. m. <i>—</i>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <i>Shady Side</i>		20f. (City or town) (County) (State) <i>Shady Side</i>	
21. I certify that I attended the deceased from <i>19</i> to <i>19</i> , that I last saw the deceased alive on <i>12</i> , and that death occurred at <i>2:00 PM</i> , from the causes and on the date stated above. ACTUAL SIGNATURE <i>Franklin D Hendricks</i> ADDRESS (Street, city or town, state) <i>Shady Side, Maryland</i> DATE SIGNED <i>11/11/56</i>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		22b. DATE THEREOF <i>11/13/56</i>	
22c. NAME OF CEMETERY OR CREMATORIUM <i>Scott's</i>		22d. LOCATION (City, town, or county) (State) <i>Shady Side</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>Bernard Hardisty</i>		24a. REC'D BY REGISTRAR DATE <i>10 - 10/11/56</i>	
		24b. REGISTRAR'S SIGNATURE	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be signed by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the offending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 7 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

10949

10920 CERTIFICATE OF DEATH

Reg. Dist. No.

21

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)	
<i>Anne Arundel Maryland</i>		a. STATE <i>Maryland</i>	b. COUNTY <i>A. A. Co.</i>
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Annapolis</i>	c. LENGTH OF STAY IN 1b	c. CITY OR TOWN (If not in hospital, write RURAL and give nearest town) <i>Annapolis</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>A. A. General Hosp.</i>	d. STREET ADDRESS <i>47 Dean Street</i>	e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <i>Robert L. Sharps</i>	First <i>Robert</i>	Middle <i>L.</i>	Last <i>Sharps</i>
4. DATE OF DEATH <i>11 6 1956</i>	Month <i>11</i>	Day <i>6</i>	Year <i>1956</i>
5. SEX <i>Male</i>	6. COLOR OR RACE <i>Col.</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>11-28-1917</i>
9. AGE (In years last birthday) <i>38 yrs</i>	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Laborer</i>	11. KIND OF BUSINESS OR INDUSTRY	12. BIRTHPLACE (State or foreign country) <i>Annapolis, Md.</i>
13. FATHER'S NAME <i>Robert L. Sharps</i>	14. MOTHER'S MAIDEN NAME <i>Carrie E. Turner</i>	15. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	
16. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, No, Unknown) <i>No</i>	17. SOCIAL SECURITY NO. <i>213-12-9670</i>	18. INFORMANT <i>Carrie E. Turner - 47 Dean St. Annapolis, Md.</i>	Address
19. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>74.</i> DUE TO <i>Loss of Adrenocortical & Neck Mandibular lymph.</i>		INTERVAL BETWEEN ONSET AND DEATH <i>1 mo.</i>	
Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause lost. (b) DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. <i>19</i>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <i>37 Dean Street</i>
20f. (City or town) <i>Annapolis, Md.</i>		(County)	(State)
21. I certify that I attended the deceased from <i>6/25</i> , 19 <i>56</i> , to <i>11/6</i> , 19 <i>56</i> that I last saw the deceased alive on <i>11/6</i> , 19 <i>56</i> , and that death occurred at <i>12:50 P.M.</i> from the causes and on the date stated above.			
ACTUAL SIGNATURE <i>Theodore H. Johnson</i>	PHYSICIAN'S NAME (Type) <i>Dr. THEODORE H. JOHNSON</i>	ADDRESS (Street, city or town, hotel) <i>37 Dean Street</i>	DATE SIGNED <i>11/6/56</i>
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>	22b. DATE THEREOF <i>11-9-56</i>	22c. NAME OF CEMETERY OR CREMATORIUM <i>Brewer Hill</i>	22d. LOCATION (City, town, or county) (State) <i>Annapolis, Md.</i>
23. FUNERAL DIRECTOR'S SIGNATURE <i>William Dean II - Annapolis, Md.</i>	ADDRESS <i>William Dean II - Annapolis, Md.</i>	24a. REC'D BY REGISTRAR <i>John French</i>	24b. REGISTRAR'S SIGNATURE <i>John French</i>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4
 may be signed by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, it should be filed with page 3
 the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10th —

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10950

10959

CERTIFICATE OF DEATH

Reg. Dist. No. 74

1. PLACE OF DEATH COUNTY CITY (If outside corporate limits, write RURAL OR TOWN) ANNE ARUNDEL		2. USUAL RESIDENCE (HOME) OF DECEASED STATE CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN MARYLAND	
HOSPITAL OR INSTITUTION OR STREET ADDRESS PLAZA MANOR CONV. HOME		STREET ADDRESS 2246 Madison Ave.	
3. NAME OF DECEASED (Type or Print) MARY (Corporate) SMITH		4. DATE OF DEATH Nov 16 1956	
5. SEX F	6. COLOR OR RACE C	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Married Dec 25	8. DATE OF BIRTH 58 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Domestic		10b. KIND OF BUSINESS OR INDUSTRY	
13. FATHER'S NAME Unknown		11. BIRTHPLACE (State or foreign country) Balto.	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) No		14. MOTHER'S MAIDEN NAME Sadie Ridgeway	
16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS Ernest Smith	
18. MEDICAL CERTIFICATION I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH IMMEDIATE CAUSE (A) Bronchopneumonia ANTECEDENT CAUSE(S) DUE TO (B) Diabetes Mellitus DISEASES OR CONDITIONS, IF ANY, (B) GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C) Hypertension II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.			
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED While <input type="checkbox"/> at work <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>	
21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from Nov 14 1956 to Nov 16 1956 , that I last saw the deceased alive on Nov 14 1956 and that death occurred at 3:30 A.M. from the causes and on the date stated above.			
SIGNATURE John W. FALER		ADDRESS (Street, city, town, state) 108-B 30th Street, Baltimore, Md.	
DATE SIGNED Nov. 16, 1956		DATE SIGNED Nov. 16, 1956	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL		DATE THEREOF 11-19-56	
NAME OF CEMETERY OR CREMATORIAL Mt. AUBURN		LOCATION (City, town, or county) BALTIMORE MD	
24. REC'D BY REGISTRAR REGISTRAR'S SIGNATURE		25. FUNERAL DIRECTOR'S SIGNATURE Wm. A. Jackson Inc.	
DATE Nov 16, 1956		ADDRESS 916 Pennsylvania Ave.	

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12 A.D.

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-51 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

10951

1092 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH			2. USUAL RESIDENCE (HOME) OF DECEASED		
COUNTY Anne Arundel	MARYLAND	STATE Md.	COUNTY A.A. Co.		
CITY (If outside corporate limits, write RURAL OR end give nearest town) TOWN Annapolis	LENGTH OF STAY (In this place)	TOWN Annapolis, Md.	CITY (If outside corporate limits, write RURAL and give nearest town) TOWN STREET ADDRESS BEST GATE		
HOSPITAL OR INSTITUTION OR STREET ADDRESS A.A. GENERAL Hosp.					
3. NAME OF DECEASED (First) SARAH (Middle) ELLEN (Last) Smith			4. DATE OF DEATH 11 12 1956		
5. SEX F	6. COLOR OR RACE W	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) MARRIED	8. DATE OF BIRTH 12/13/1886	9. AGE last birthday 69 yrs.	IF UNDER 1 YEAR Months Days Hours Min.
10e. USUAL OCCUPATION (Give kind of work done during most of work no life, even if retired) HOME		10b. KIND OF BUSINESS OR INDUSTRY HOUSEWIFE	11. BIRTHPLACE (State or foreign country) MARYLAND	12. CITIZEN OF WHAT COUNTRY U.S.A.	
13. FATHER'S NAME John W. SEARS			14. MOTHER'S MAIDEN NAME Mary Wood		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.)		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS THOMAS A. Smith #2	
18. MEDICAL CERTIFICATION					
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH 420.1 IMMEDIATE CAUSE (A) Posterior Myocardial infarction ANTECEDENT CAUSE(S) DUE TO 6/16. DISEASES OR CONDITIONS, IF ANY, (B) Coronary artery disease GIVING RISE TO THE ABOVE CAUSE DUE TO 4 yr STATING UNDERLYING CAUSE LAST. (C)					
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.					
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED M. at work <input type="checkbox"/> Not white <input type="checkbox"/> at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from March 1953 to November 1956, that I last saw the deceased alive on 11/12/1957, and that death occurred at 2:30 P.M. from the causes and on the date stated above. SIGNATURE <i>Frank W. Shadley</i> ADDRESS (Street, city, town, state) DATE SIGNED <i>6/3 College Ave Annapolis 11/13/56</i>					
23. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL		DATE THEREOF 11/14/56		NAME OF CEMETERY OR CREMATORIAL EDWARDS CHAPEL	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE		LOCATION (City, town, or county) Annapolis, Md. (State)	
DATE		25. FUNERAL DIRECTOR'S SIGNATURE <i>John W. Shadley & Sons Annapolis, Md.</i> ADDRESS			

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10952

10960 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Anne Arundel MARYLAND		2. USUAL RESIDENCE (Where deceased lived if institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Crownsville		c. LENGTH OF STAY IN 1b 7 yrs. 5 days	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Crownsville State Hospital		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Turner's Station, Baltimore 22,	
3. NAME OF DECEASED First Melvin Middle Sorrell Last		d. STREET ADDRESS 627 Maine Street	
(Type or print)		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
5. SEX Male	6. COLOR OR RACE Negro	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 6/1/19
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer		10b. KIND OF BUSINESS OR INDUSTRY Unknown	
10c. FATHER'S NAME Julian Sorrell		11. BIRTHPLACE (State or foreign country) Virginia	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) Unk.		16. SOCIAL SECURITY NO. Unk.	
17. INFORMANT Hospital Records		12. CITIZEN OF WHAT COUNTRY? U. S.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]		19. INTERVAL BETWEEN ONSET AND DEATH	
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Uremia			
DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.			
{ (b) Renal Failure, arteriosclerotic			
DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
Dehydration and Malnutrition			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from _____ alive on _____ and that death occurred at _____		11/13 1956 to 11/13 1956 that I last saw the deceased at 11:45a.m. from the causes and on the date stated above.	
ACTUAL SIGNATURE <i>Lionel McHenry Mapp.</i>		ADDRESS (Street, city or town, state) M.D. Crownsville, Maryland DATE SIGNED 11/13/56	
PHYSICIAN'S NAME (Type) Lionel McHenry Mapp.		22a. BURIAL, CREMATION, REMOVAL (Specify) 11/20/56 22b. DATE THEREOF 11/20/56 22c. NAME OF CEMETERY OR CREMATORIAL M. J. Oberonian Bo. 5 Lot 1 22d. LOCATION (City, town, or county) (State)	
23. FUNERAL DIRECTOR'S SIGNATURE <i>E. H. Akers 9/13 Stack Hill</i>		24a. REC'D BY REGISTRAR- DATE	
ADDRESS		24b. REGISTRAR'S SIGNATURE <i>J. M. Joyce</i>	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be signed by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10961 CERTIFICATE OF DEATH

10953

Reg. Dist. No. 28

1. PLACE OF DEATH a. COUNTY Anne Arundel MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Maryland b. COUNTY Baltimore City	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Crownsville		c. LENGTH OF STAY IN lb 3 yrs. 4 mos. 24 days Baltimore City	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Crownsville State Hospital		d. STREET ADDRESS 3806 Fear Avenue	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)	First Ida	Middle Moore	Last Spencer
4. DATE OF DEATH	Month 11	Day 13	Year 1956
5. SEX Female	6. COLOR OR RACE Negro	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH 5/6/76
9. AGE (In years lost birthday) 80 yrs		10. IF UNDER 1 YEAR Months —	11. IF UNDER 24 HRS. Hours —
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laundress		10b. KIND OF BUSINESS OR INDUSTRY —	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U. S.	
13. FATHER'S NAME James Spencer		14. MOTHER'S MAIDEN NAME Ellen Ross Moore	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. Hospital Records	
17. INFORMANT Address Crownsville State Hospital Crownsville, Maryland		INTERVAL BETWEEN ONSET AND DEATH	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Hypostatic Pneumonia 522X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Old age DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Dehydration, malnutrition, decubitus ulcers			
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour a. m. p. m.	Month 19	Day	Year
20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 10/17, 1956, to 11/13, 1956, that I last saw the deceased alive on 11/13, 1956, and that death occurred at 4:45 P.M. from the causes and on the date stated above. ACTUAL SIGNATURE Lionel McHenry Map, M.D. ADDRESS (Street, city or town, state) Crownsville, Md. DATE SIGNED 11/14/56			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 10/17/56	
22c. NAME OF CEMETERY OR CREMATORIAL Graves Memorial Cemetery		22d. LOCATION (City, town, or county) Washington D.C.	
23. FUNERAL DIRECTOR'S SIGNATURE Droy Wilson		ADDRESS 1000 Franklin Street, Baltimore	
24a. REC'D BY REGISTRAR DATE 11-23-06		24b. REGISTRAR'S SIGNATURE Matthew Joyce	



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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10954

10962 CERTIFICATE OF DEATH

Reg. Dist. No. 26

1. PLACE OF DEATH a. COUNTY Anne Arundel MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Prince George's	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Deale		c. LENGTH OF STAY IN lb Transient	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Beele Rd. d		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Upper Marlboro	
3. NAME OF DECEASED First George Middle William Last Sturgess		d. STREET ADDRESS Rt. 2., Box 237	
(Type or print)		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH March 17, 1877
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Tobacco Farmer		10b. KIND OF BUSINESS OR INDUSTRY Own Farm	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME Samuel Sturges		14. MOTHER'S MAIDEN NAME Mary E. Sturges Windsor	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 17. INFORMANT James E. Sturges, Jr., Box 237, Upper Marlboro, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Congestive Heart Disease</i>		INTERVAL BETWEEN ONSET AND DEATH <i>5 days</i>	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>Arteriosclerotic CV Disease</i>			
DUE TO (c) <i></i>			
Part II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. p. 19 p. m. <i></i>		20d. INJURY OCCURRED White Not white at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <i>Sept. 1936</i> to <i>23 Nov. 1956</i> , that I last saw the deceased alive on <i>19 Nov. 1956</i> , and that death occurred at <i>Upper Marlboro, Md.</i> from the causes and on the date stated above. ADDRESS (Street, city or town, state) ACTUAL SIGNATURE <i>J. E. Sturges</i> DATE SIGNED <i>11/23/56</i> PHYSICIAN'S NAME (Type) <i>R. E. Sappier, M. D.</i>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Urns</i>		22b. DATE THEREOF <i>11/27/56</i>	
22c. NAME OF CEMETERY OR CREMATORIAL <i>Trinity Cemetery</i>		22d. LOCATION (City, town, or county) (State) <i>Upper Marlboro, Maryland</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>Rite Bros. Upper Marlboro, Maryland</i>		24a. REC'D BY REGISTRAR <i>VS A15 (4)</i> DATE <i>Nov 30 1956 - J. B. Dent</i>	
ADDRESS <i></i>		24b. REGISTRAR'S SIGNATURE <i></i>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death; Page 4 may be signed by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician it must be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

Y. S.
LUDWIG

11-10-02

11-10-02

10963

CERTIFICATE OF DEATH

Reg. Dist. No.

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

1. PLACE OF DEATH COUNTY CITY (If outside corporate limits, write RURAL OR end give nearest town) TOWN		MARYLAND LENGTH OF STAY (In this place)		2. USUAL RESIDENCE (HOME) OF DECEASED STATE CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN		COUNTY STREET ADDRESS	
Arnold				Md.		Arnold	
HOSPITAL OR INSTITUTION OR STREET ADDRESS							
3. NAME OF DECEASED (Type or Print)		(First) Edith (Middle) Elizabeth (Last)		4. DATE OF DEATH		(Month) (Day) (Year)	
S. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	B. DATE OF BIRTH	9. AGE last birthday	IF UNDER 1 YEAR		IF UNDER 24 HRS.
Female	White	Married	2-23-1894	62 yrs.	Months	Days	Hours Min.
10a. USL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY	
Housewife		Home		Prince George Co Md		Va. S.A	
13. FATHER'S NAME		James Arnold		14. MOTHER'S MAIDEN NAME		Unknown	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.)		(If Yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS	
						Alvin Shieme (2)	
18. MEDICAL CERTIFICATION I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH IMMEDIATE CAUSE (A) <i>Dyspnea due to Paralysis of the</i> ANTECEDENT CAUSE(S) DUE TO <i>Throat</i> DISEASES OR CONDITIONS, IF ANY, (B) GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO <i>Hypertension - Agraphia.</i> (C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		(State)	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County)		(State)	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED M. While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from April 9, 1954, to Nov. 16, 1956, that I last saw the deceased alive on Nov. 16, 1956, and that death occurred at 6:00 PM, from the causes and on the date stated above. SIGNATURE <i>J. G. de Cacerdo</i> M.D. ADDRESS (Street, city, town, state) <i>Arnold Rd</i> DATE SIGNED <i>Nov. 19, 1956</i>							
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>Natural</i>		DATE THEREOF <i>11-19-56</i>		NAME OF CEMETERY OR CREMATORIUM <i>Asbury Cemetery Arnold</i>		LOCATION (City, town, or county) (State) <i>Md</i>	
24. REC'D BY REGISTRAR VS AISC 1-55 10A DATE 11-21-56		REGISTRAR'S SIGNATURE <i>G. French</i>		25. FUNERAL DIRECTOR'S SIGNATURE <i>Jeffreys City Corson Indianapolis</i>		ADDRESSES <i>Ind</i>	

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
10956
21
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be given to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for files.

FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File Pages 1 and 2 with the registrar prior to burial; cremation, or removal.

1. PLACE OF DEATH a. COUNTY <i>Anne Arundel</i>		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <i>Maryland</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Annapolis</i>	c. LENGTH OF STAY IN 1b <i>60 Larkin St</i>	d. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Annapolis</i>	e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <i>60 Larkin St</i>		d. STREET ADDRESS <i>60 Larkin St</i>	
3. NAME OF DECEASED (Type or print) <i>George</i>	First <i>Thomas</i>	Middle <i>Thomas</i>	Last <i>11/12/1956</i>
4. DATE OF DEATH <i>10-11-1866</i>	Month <i>90</i>	Day <i>11</i>	Year <i>1956</i>
5. SEX <i>Male</i>	6. COLOR OR RACE <i>Coll</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>	8. DATE OF BIRTH <i>10-11-1866</i>
WIDOWED <input type="checkbox"/>	DIVORCED <input type="checkbox"/>	9. AGE (In years for birthday) 90 yrs.	
10a. USUALLY OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Handyman</i>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <i>Rutland, Md</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	
13. FATHER'S NAME <i>John Henry Thomas</i>		14. MOTHER'S MAIDEN NAME <i>Elizabeth Thomas</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <i>No</i>		16. SOCIAL SECURITY NO. <i>Mary Thomas - 60 Larkin St</i>	
17. INFORMANT <i>Mary Thomas - 60 Larkin St</i>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>450.0</i> DUE TO <i>Undercoatsides paralyzed</i> INTERVAL BETWEEN ONSET AND DEATH			
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause first. (b) _____			
DUE TO (c) _____			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE <i>George</i>		DATE SIGNED <i>11/12/56</i>	
EXAMINER'S NAME (Type) <i>E. Linhardt</i>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		22b. DATE THEREOF <i>11-15-56</i>	
22c. NAME OF CEMETERY OR CREMATORIAL <i>Brewer Hill</i>		22d. LOCATION (City, town, or county) <i>Annapolis, Md</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>William Rees, Jr.</i>		ADDRESS <i>Annapolis, Md</i>	
24a. READ BY REGISTRAR <i>Nov. 15, 1956</i>		24b. REGISTRAR'S SIGNATURE <i>J. Frenchy</i>	

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1 DUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be given to the Chief Medical Examiner's Office along with farm PM3. Page 5 may be retained for files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 MEDICAL EXAMINER'S CERTIFICATE OF DEATH												Reg. Dist. No. 10957			
1. PLACE OF DEATH a. COUNTY Anne Arundel				MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission)							
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Linthicum				c. LENGTH OF STAY IN TB 14 years				d. STATE Same				b. COUNTY Same			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Hammonds Ferry Road Box 272								c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Same				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)		First Richard		Middle Celestine		Last Towson		4. DATE OF DEATH November 22		Month Day Year 19 56					
5. SEX M		6. COLOR OR RACE W.		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		8. DATE OF BIRTH 6/19/56 1881		9. AGE (In years last birthday) 75 80 yrs.		10. IF UNDER 1YEAR Months 0 Days 0 Hours 0 Min. 0		11. IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired carpenter				10b. KIND OF BUSINESS OR INDUSTRY				11. BIRTHPLACE (State or foreign country) Baltimore Md.				12. CITIZEN OF WHAT COUNTRY? U.S.A.			
13. FATHER'S NAME John Towson				14. MOTHER'S MAIDEN NAME Estelle ?											
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No				16. SOCIAL SECURITY NO. 214-05-2988				17. INFORMANT Mrs Estelle Towson (wife)				Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]												INTERVAL BETWEEN ONSET AND DEATH Sudden			
PART I. DEATH WAS CAUSED BY, IMMEDIATE CAUSE (a) Coronary Occlusion															
DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b)															
DUE TO (c)															
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)												19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)											
20c. TIME OF INJURY Hour a. m. p. m.		Month, Day, Year 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)							
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .															
Gustave H. Faubert M.D.												DATE SIGNED 11/23/56			
ACTUAL SIGNATURE Gustave H. Faubert M.D.				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>											
EXAMINER'S NAME (Type) Gustave H. Faubert M.D.															
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Nov. 26-56		22c. NAME OF CEMETERY OR CREMATORIUM Loudon Park Cemetery		22d. LOCATION (City, town, or county) Baltimore City Maryland		(State)							
23. FUNERAL DIRECTOR'S SIGNATURE Richard S. Lippert				ADDRESS Glen Burnie, Md.				24a. REC'D BY REGISTRAR DATE 11/26/1956		24b. REGISTRAR'S SIGNATURE J. J. Hedrick					

BRUNSWICK

21

1890

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M*

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

10958

10923 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH			2. USUAL RESIDENCE (HOME) OF DECEASED		
COUNTY CITY (If outside corporate limits, write RURAL OR and give nearest town) TOWN	MARYLAND	STATE CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN	COUNTY STREET ADDRESS		
ANNAPOLIS	A A GENERAL	M D	Arundel on the Bay		
3. NAME OF DECEASED (First) (Middle) (Last)			4. DATE (Month) (Day) (Year)		
WALTER L. TYLER			11 - 24 - 56		
5. SEX	6. COLOR OR RAIR	7. SINGLE, MARRIED, WIDOWED, DIVORCED, Separate	8. DATE OF BIRTH	9. AGE last birthday	IF UNDER 1 YEAR Months Days Hours Min.
MALE	WHITE	Widower	Mar. 18-1877	79 yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)			10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	
Civil Service Corp. U.S. Naval Academy			BALTIMORE Md.	U.S.A.	
13. FATHER'S NAME			14. MOTHER'S MAIDEN NAME		
Albert L. Tyler			Katherine Mason		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)			16. SOCIAL SECURITY NO.	17. INFORMANT & ADDRESS	
No Spanish American War				Mrs Clifford Jones Annapolis Md. 697 State St	
18. MEDICAL CERTIFICATION			INTERVAL BETWEEN ONSET AND DEATH		
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH			2 wks. 4 wks. 6 wks. 6 wks.		
IMMEDIATE CAUSE (A)			Chronic Nephritis		
ANTECEDENT CAUSE(S) DUE TO (B)			Atherosclerotic Heart Disease		
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C)			Coronary Thrombosis		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION ON CAUSING DEATH.					
19a. DATE OF OPERATION			19b. MAJOR FINDINGS OF OPERATION		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)			21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)		
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)			21e. HOW DID INJURY OCCUR?		
M. at work <input type="checkbox"/> Not white <input type="checkbox"/> at work <input type="checkbox"/>					
22. I hereby certify that I attended the deceased from Oct. 1, 1956, to Nov. 24, 1956, that I last saw the deceased alive on Nov. 24, 1956, and that death occurred at 10 AM, from the causes and on the date stated above.					
SIGNATURE <i>James D. Martin</i> ADDRESS <i>185 Prince George St. Annapolis Md.</i> DATE SIGNED <i>11/24/56</i>					
23. BURIAL, CREMATION, REMOVAL (SPECIES) Burial			DATE THEREOF 11-27-56 NAME OF CEMETERY OR CREMATORIUM HILLCREST		
24. REC'D BY REGISTRAR DATE			25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <i>John W. Taylor bus Annapolis Md.</i>		

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10959

10924 CERTIFICATE OF DEATH

Reg. Dist. No. 21

1. PLACE OF DEATH a. COUNTY <i>Anne Arundel</i>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <i>Maryland</i>		b. COUNTY <i>Anne Arundel</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Annapolis</i>		c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Riva</i>		d. STREET ADDRESS	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Riviera Anne Arundel General Hospital</i>						e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)	First <i>William</i>	Middle <i>E</i>	Last <i>Van Hart</i>	4. DATE OF DEATH	Month <i>November</i>	Day <i>9</i>	Year <i>1956</i>
5. SEX <i>Male</i>	6. COLOR OR RACE <i>White</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH <i>June 12, 1882</i>	9. AGE (In years last birthday) <i>74</i> yrs.	10. IF UNDER 1 YEAR Months <i>0</i>	11. IF UNDER 24 HRS. Days <i>0</i>	12. IF UNDER 24 HRS. Hours <i>0</i>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Retired - Supt.</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Apt. House</i>		11. BIRTHPLACE (State or foreign country) <i>New York</i>		12. CITIZEN OF WHAT COUNTRY? <i>USA</i>	
13. FATHER'S NAME <i>Unknown</i>				14. MOTHER'S MAIDEN NAME <i>Unknown</i>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>		16. SOCIAL SECURITY NO. <i>101-03-0071</i>		17. INFORMANT <i>Mrs. Alice Stanton- Daughter- same as # 2</i>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <i>Myocardial infarction, antero-septal coronary artery occlusion coronary arteriosclerosis.</i>							
INTERVAL BETWEEN ONSET AND DEATH							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. [Enter nature of injury in Part I or Part II of item 18.]					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <i>19</i>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <i>11/8</i> , 19 <i>57</i> , to <i>11/7</i> , 19 <i>58</i> , that I last saw the deceased alive on <i>11/9</i> , 19 <i>56</i> , and that death occurred at <i>5:45</i> A.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) <i>Cathedral St. Annapolis, Md.</i>							
DATE SIGNED <i>11/14/56</i>							
ACTUAL SIGNATURE <i>John H. Hedeman</i>							
PHYSICIAN'S NAME (Type) <i>John Hedeman</i> MD							
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Removal-Burial 11-13-56</i>		22b. DATE THEREOF <i>11-13-56</i>		22c. NAME OF CEMETERY OR CREMATORIUM <i>Mt. Olivet Cemetery</i>		22d. LOCATION (City, town, or county) (State) <i>Maspeth, Long Island, New York</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>Hopkins Funeral Home</i>		ADDRESS <i>172 West St. Annapolis, Md.</i>		24a. REC'D. BY REGISTRAR- <i>1956</i>		24b. REGISTRAR'S SIGNATURE <i>Wm. J. French</i>	

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10955 CERTIFICATE OF DEATH

10960
28

Reg. Dist. No.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1, 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY Anne Arundel		MARYLAND		2. USUAL RESIDENCE (Where deceased lived if institution Residence before admission) a. STATE MD		b. COUNTY BALTIMORE					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CROWNSVILLE, ANNAPOLIS		c. LENGTH OF STAY IN 1b 9 yrs 5m 0s		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) BALTIMORE							
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION CROWNSVILLE STATE		d. STREET ADDRESS 311 N STRICKER ST		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) MARY Antoinette WADE		First Mary	Middle Antoinette	Last WADE	4. DATE OF DEATH Nov 17	Month Nov	Day 17	Year 1956			
5. SEX F	6. COLOR OR RACE N	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>		8. DATE OF BIRTH WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> NOV 8, 1885	9. AGE (in years lost birthday) yrs. 71	10. IF UNDER 1 YEAR Month 0	11. IF UNDER 24 HRS Days 0				
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) UNKNOWN		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Md		12 CITIZEN OF WHAT COUNTRY? USA					
13. FATHER'S NAME John Henry F. WADE		14 MOTHER'S MAIDEN NAME ANNA Legion		Address							
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO.		17. INFORMANT		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) HEART FAILURE DUE TO 42d.1 Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause first. (b) AURICULAR FIBRILLATION DUE TO (c) Arterosclerotic CARDIOVASCULAR DISEASE					
Part II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) MALNUTRITION		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>									
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Nov 15 , 1956, to Nov 17 , 1956, that I last saw the deceased alive on Nov 17 , 1956, and that death occurred at 7:45 PM, from the causes and on the date stated above.		ADDRESS (Street, city or town, state) Crownsville Md. 11-18-56		DATE SIGNED							
ACTUAL SIGNATURE George E. M. Phillips		M.D.		PHYSICIAN'S NAME (Type) GEORGE E. M. PHILLIPS		CROWNSVILLE MD					
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 11-20-56		22c. NAME OF CEMETERY OR CREMATORIUM arbutus		22d. LOCATION (City, town, or county) md					
23. FUNERAL DIRECTOR'S SIGNATURE George S. Nelson		ADDRESS 1348 N. Calhoun St.		24a. REC'D BY REGISTRAR DATE 19		24b. REGISTRAR'S SIGNATURE H. M. Joyce					

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10961

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH, o. COUNTY <i>A. Co.</i>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived if institution, Residence before admission) o STATE <i>MD.</i> b. COUNTY <i>A.A.Co.</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Annapolis</i>		c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Annapolis</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>179 GREEN ST.</i>		d. STREET ADDRESS <i>179 GREEN ST.</i>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)	First <i>SUSIE</i>	Middle <i>P.</i>	Last <i>WARD</i>	Month <i>Nov.</i>	Day <i>25</i>
5. SEX <i>F</i>	6. COLOR OR RACE <i>W</i>	7. MARRIED <input type="checkbox"/> NEVER-MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>2/14/1888</i>	9. AGE (in years less birthday) <i>68 yrs.</i>	IF UNDER 1 YEAR IF UNDER 24 HRS Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>HOME</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>HOUSEWIFE</i>		11. BIRTHPLACE (State or foreign country) <i>MARYLAND</i>	
13. FATHER'S NAME <i>"unk"</i>		14. MOTHER'S MAIDEN NAME <i>"unk"</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes or no or unknown) —		16. SOCIAL SECURITY NO. —		17. INFORMANT <i>Mrs. ROSIE SCURRY #2</i>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)		Address			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last.		INTERVAL BETWEEN ONSET AND DEATH MINUTES <i>CORONARY OCCLUSIVE</i>			
(b) DUE TO <i>HYPERTENSIVE CARDIO-VASCULAR DIS.</i>		<i>10 YRS.</i>			
(c)					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <i>JAN.</i> 19.56 to <i>NOV. 25.</i> 19.56, that I last saw the deceased alive on <i>25 NOV.</i> 19.56, and that death occurred at <i>11 AM</i> , from the causes and on the date stated above.					
ACTUAL SIGNATURE <i>Edward S. Beck</i>		ADDRESS (Street, city or town, state) <i>41 Southgate Ave Annapolis</i>			
PHYSICIAN'S NAME (Type) <i>EDWARD S. BECK MD</i>		DATE SIGNED <i>11/29/56</i>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>BURIAL</i>		22b. DATE THEREOF <i>11/29/56</i>		22c. NAME OF CEMETERY OR CREMATORIUM <i>CEDAR Bluff</i>	
22d. LOCATION (City, town, or county) <i>ANNAPOLIS</i>		(State) <i>MD.</i>			
23. FUNERAL DIRECTOR'S SIGNATURE <i>John M. Taylor & Sons</i>		ADDRESS <i>Annapolis, Md.</i>		24a. REC'D BY REGISTRAR DATE	
				24b. REGISTRAR'S SIGNATURE	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 13 by the funeral director.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 & 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

LEAU V. A.

1956

LEAU V. A.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12086

10965 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. 28

1. PLACE OF DEATH a. COUNTY <i>Anne Arundel</i>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>MARYLAND</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>GAMBRILLS</i>	c. LENGTH OF STAY IN lb	b. COUNTY	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>X</i>	
d. STREET ADDRESS		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <i>MARY</i>	First	Middle	Last <i>WARREN</i>
4. DATE OF DEATH <i>11/12/56</i>	Month	Day	Year
5. SEX <i>F</i>	6. COLOR OR RACE <i>C</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>53 yrs.</i>
9. AGE (In years last birthday)		10. IF UNDER 1 YEAR Months <i>5</i> Days <i>3</i>	11. IF UNDER 24 HRS. Hours <i>12</i> Min. <i>56</i>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. 17. INFORMANT Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Skull Fracture</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last <i>Fracture of neck</i> IMMEDIATE CAUSE (b) <i>Compound Comminuted Fracture of both lower legs</i> IMMEDIATE CAUSE (c) <i>Pedestrian hit by auto</i>			
INTERVAL BETWEEN ONSET AND DEATH			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (c)			
20a. EXTERNAL CAUSE WAS FROM MARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.			
20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.) <i>Pedestrian hit by auto</i>			
20c. TIME OF INJURY Month, Day, Year Hour <i>a.m.</i> 11 / 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, offce, bldg., etc.) <i>street</i>
20f. (City or town) <i>Anne Arundel Md.</i>		(County) <i>Anne Arundel</i> (State) <i>Md.</i>	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE <i>William W. Woods</i>	DATE SIGNED <i>11-12-56</i>		
EXAMINER'S NAME (Type)	M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/>		
22a. BURIAL, CREMATION, REMOVAL (if any) <i>Burial</i>	22b. DATE THEREOF <i>12-21-56</i>	22c. NAME OF CEMETERY OR CREMATORIUM <i>C. of Med. Med-School</i>	22d. LOCATION (City, town, or county) (State) <i>Baltimore, Md.</i>
23. FUNERAL DIRECTOR'S SIGNATURE	ADDRESS	24a. REC'D BY REGISTRAR DATE	24b. REGISTRAR'S SIGNATURE

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute an certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be given to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for records.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

WIREAU V. S

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10962

10926 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <i>Annapolis</i>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>Md.</i> b. COUNTY <i>Annapolis</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Annapolis</i>	c. LENGTH OF STAY IN lb <i>General Hosp.</i>	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>South River Park</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>General Hosp.</i>		d. STREET ADDRESS	
		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	

3. NAME OF DECEASED (Type or print) <i>Robert</i>	First <i>R</i>	Middle <i>N</i>	Last <i>Williams</i>	4. DATE OF DEATH <i>11-15 1956</i>
5. SEX <i>Male</i>	6. COLOR OR RACE <i>White</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>Aug 31-1904</i>	9. AGE (In years last birthday) <i>52 yrs.</i>
10a. USUAL OCCUPATION (Give kind of work done during most working life, even if retired) <i>Salesman</i>	10b. KIND OF BUSINESS OR INDUSTRY <i>Stoves</i>	10c. BIRTHPLACE (State or foreign country) <i>Washington DC</i>	10d. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	
13. FATHER'S NAME <i>William Williams</i>	14. MOTHER'S MAIDEN NAME <i>Flora Smith</i>	Address <i>Marion H. Williams</i> (2)		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>Yes</i>	16. SOCIAL SECURITY NO. <i>World War II</i>	17. INFORMANT <i>Marion H. Williams</i>		

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)		INTERVAL BETWEEN ONSET AND DEATH
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Cerebrovascular accident</i>		2 minutes
DUE TO <i>443X</i>		
Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause first. (b) <i>Hypertensive cardiovascular Disease</i>		2 years
DUE TO <i>443X</i>		
(c)		

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
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20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <i>19</i>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) <i>11/2 1956</i>	(County) (State)

21. I certify that I attended the deceased from <i>11/2 1956</i> to <i>11/15 1956</i> that I last saw the deceased alive on <i>11/15 1956</i> , and that death occurred at <i>20 Cathedral St.</i> M., from the causes and on the date stated above.				
ADDRESS (Street, city or town, state) <i>Annapolis, Md.</i>				

ACTUAL SIGNATURE <i>John L. (Redfern)</i>	DATE SIGNED <i>11/16/56</i>			
PHYSICIAN'S NAME (Type) <i>John M. Taylor Sons Annapolis Md</i>				

22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>	22b. DATE THEREOF <i>11-17-56</i>	22c. NAME OF CEMETERY OR CREMATORIUM <i>Washington National</i>	22d. LOCATION (City, town, or county) <i>Annapolis</i>	(State) <i>Md.</i>
23. FUNERAL DIRECTOR'S SIGNATURE <i>John M. Taylor Sons Annapolis Md</i>	ADDRESS <i>Annapolis, Md.</i>	24a. REC'D BY REGISTRAR <i>J. W. Smith</i>	24b. REGISTRAR'S SIGNATURE <i>J. W. Smith</i>	DATE <i>11-17-56</i>

CERTIFICATE OF DEATH

RECEIVED

BUREAU V. S.

NOV 19 1956

RECEIVED

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

The bottom copy may be retained by the hospital or attending physician.
VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

Item 11 Film G207 11-21-56 et

10963

10967 CERTIFICATE OF DEATH

Reg. Dist. No. 28

1. PLACE OF DEATH

COUNTY Anarundel

MARYLAND

CITY (If outside corporate limits, write RURAL
OR end give nearest town)

TOWN Millersville

LENGTH OF STAY
(in this place)HOSPITAL OR
INSTITUTION OR
STREET ADDRESS

Banns Nursing Home.

2. USUAL RESIDENCE (HOME) OF DECEASED

STATE Maryland

COUNTY Arundel

CITY (If outside corporate limits, write RURAL and give nearest town)
OR
TOWN Herald HarborSTREET
ADDRESS

(If rural give location)

3. NAME OF
DECEASED
(Type or Print)

(First) Frederick W. Willner (Middle)

(Last)

4. DATE (Month)

(Day)

(Year)

5. SEX

6. COLOR OR
RACE7. SINGLE, MARRIED,
WIDOWED, DIVORCED,

8. DATE OF BIRTH

9. AGE last birthday

IF UNDER 1 YEAR

IF UNDER 24 HRS.

Male

white

Married

May 8, 1874

82

yrs.

Months

Days

Hours

Min.

10a. USUAL OCCUPATION (Give kind of work
done during most of working life, even if
retired)10b. KIND OF BUSINESS
OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

12. CITIZEN OF WHAT
COUNTRY?

Washington, D.C.

13. FATHER'S NAME

Francis H Willner

14. MOTHER'S MAIDEN NAME

Frances Mulligan

15. WAS DECEASED EVER IN U. S. ARMED FORCES?
(Yes, no, or unk.)

(If Yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT & ADDRESS

Warren H Willner-Herald Harbor, Md.

I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

450.0 IMMEDIATE CAUSE

(A)

Generalized Arteriosclerosis

INTERVAL BETWEEN
ONSET AND DEATH

5 years

ANTECEDENT CAUSE(S) DUE TO

DISEASES OR CONDITIONS, IF ANY, (B)
GIVING RISE TO THE ABOVE CAUSE
STATING UNDERLYING CAUSE LAST. DUE TO

704.9 (C)

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING DEATH.

Fractured LEFT Femur

4 mo

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES NO 21a. ACCIDENT WAS UNDERLYING
OR CONTRIBUTING CAUSE OF DEATH
(If either, NOTIFY MEDICAL EXAMINER)21b. PLACE (Home, farm, factory,
OF INJURY street, office bldg., etc.)

21c. WHERE DID INJURY OCCUR? (City or town)

(County)

(State)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)

21e. INJURY OCCURRED

21f. HOW DID INJURY OCCUR?

M. While at work Not while at work at work

22. I hereby certify that I attended the deceased from Sept.

alive on Nov 12, 1956, to Nov 12, 1956, that I last saw the deceased
and that death occurred at 8:45 A.M. from the causes and on the date stated above.

SIGNATURE

Edward J. Henrich

ADDRESS (Street, city, town, state)

DATE SIGNED

11-12-56

23. BURIAL, CREMATION,
REMOVAL (SPECIFY)

Burial

DATE THEREOF

11-14-56

NAME OF CEMETERY OR CREMATORIUM

Cedar Hill

LOCATION (City, town, or county)

(State)

Suitland, Md.

24. REC'D BY REGISTRAR

Nov 14 1956

DATE

REGISTRAR'S SIGNATURE

M. Joyce

25. FUNERAL DIRECTOR'S SIGNATURE

J. O'Leary

ADDRESS

Loyola Cemetery Co. Ltd. Inc.

CEMETRIE DE DEATH

RECEIVED
BUREAU V.

CV 14 1956